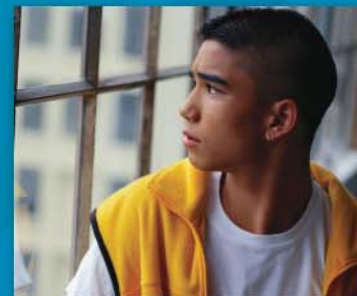


REPORT TO THE PRESIDENT AND THE NATION



**ASIAN AMERICANS AND PACIFIC ISLANDERS
ADDRESSING HEALTH DISPARITIES:
OPPORTUNITIES FOR BUILDING A HEALTHIER AMERICA**



2003



PRESIDENT'S ADVISORY COMMISSION ON ASIAN AMERICANS AND PACIFIC ISLANDERS

R E P O R T T O T H E P R E S I D E N T A N D T H E N A T I O N

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OPPORTUNITIES FOR BUILDING A HEALTHIER AMERICA**

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P R E S I D E N T ' S A D V I S O R Y C O M M I S S I O N O N A S I A N A M E R I C A N S A N D P A C I F I C I S L A N D E R S

Acknowledgments

The President's Advisory Commission on Asian Americans and Pacific Islanders wishes to thank the many individuals and organizations that helped inspire, research, and draft this report. We wish to thank President George W. Bush for his leadership and vision, and for signing Executive Order 13216 to increase opportunities for and improve the quality of life of approximately 13 million Asian Americans and Pacific Islanders living in the United States and the U.S.-associated Pacific Island jurisdictions.

We thank Secretary of Health and Human Services Tommy G. Thompson and Deputy Secretary Claude A. Allen for their leadership and support.

We would like to express our thanks to the Secretary of Labor, Elaine L. Chao, for providing the Commission with support and counsel, as well as motivation for getting the Commission up and running. To the Secretary of Transportation, Norman Y. Mineta, who served as the Commission's first Chair, we extend our heartfelt thanks.

We gratefully acknowledge Willis Morris and Regina Schofield of the Department of Health and Human Services, as well as Regional Directors who helped along the way, including Costas Miskis, Region IV; Corey Hoze, Region V; Linda Penn, Region VI; and Carolyn Oakley, Region X.

We would also like to express our gratitude to the following individuals and their community-based organizations for their contributions toward this report: Clayton Fong from the National Asian Pacific Center on Aging for initially counseling the

Commission to examine the health needs of underserved AAPIs—new immigrants, refugees, and especially seniors within our community—Jeffrey B. Caballero and Sheila K. Robello from the Association of Asian Pacific Community Health Organizations, Dr. Ho L. Tran and Gem P. Daus from the Asian and Pacific Islander American Health Forum, and Lisa Hasegawa from the National Coalition for Asian Pacific American Community Development.

This report would not have taken its shape without the many other organizations and individuals who serve the Asian American and Pacific Islander communities, and provided the Commission with invaluable information through their testimonies; so, in no particular order, we wish to thank the following individuals:

In Orange County, California—Suzie Xuyen Matsuda, Joseph Pak, Mary Anne Foo, Dr. Quynh Kieu, and Jesus Romero. In St. Paul, Minneapolis—Kayang Hang, Emily Williamson, Lee Pao Xiong, Yeu Pham, Ilean Her, and William Yang. In Atlanta, Georgia—Sister Christine Truong, Chae-wan Kim, Sumi Lee, and Yuhn Krall. From Orlando, Florida—Sylvia Yi. From Ft. Lauderdale, Florida—Dr. Joy Bruce and Dr. Antonio Wang. In Honolulu, Hawaii—Dr. Neal A. Palafox, Beth Giesting, Haunani Apoliona, Dr. Robert Tucker, Hardy Spoeher, William Kaneko, Richard Meiers, Dr. Tin Myaing Thein, and Puongpun Sananikone. From Seattle, Washington—Clayton Fong and Alaric Bien. From Dallas, Texas—Linda Do, Son Tuong Do, Grace McDermott, Jennifer Nguyen, and Y Duc Nguyen. From Houston, Texas—Dan Nip, Lishen Kline,

Stella Chan, Rogene Calvert, Nancy Liu,
Beverly Gor, and Mari Okabayashi.

The Commission also wishes to thank the
following White House Initiative on Asian
Americans and Pacific Islanders interns for
their exemplary hard work and dedication:
Andrew Kim, Michael Trinh, Hwa Kyung

Chae, Cynthia Chau, Cecelia Suhr, Hanh
Nguyen, and Christine Ho.

Finally, we wish to acknowledge the
countless individuals who willingly shared
their experiences, without whom this
report would not have come to fruition.

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Preface

FIVE STEPS TO IMPROVE THE HEALTH OF ASIAN AMERICAN AND PACIFIC ISLANDER COMMUNITIES

This report marks a major achievement for the Nation's Asian American and Pacific Islander (AAPI) communities—an achievement that would not be possible without the leadership of President George W. Bush. Over the past 2 years, the President's Advisory Commission on Asian Americans and Pacific Islanders has conducted numerous site visits and town hall meetings across the Nation. As a result of this face-to-face interaction with diverse AAPI communities, it quickly became clear that the biggest concern among AAPI communities is health.

With that concern in mind, the Commission has labored to examine the health status of AAPIs and has identified strategies for improving the health of our communities. We thank President Bush for his unswerving commitment to our communities and for giving us this critically important opportunity to present our findings through this groundbreaking report.

Long regarded as the “silent minority,” AAPIs often are perceived as compliant, passive, and self-reliant. These perceptions evolve from a strong sense of pride, a reluctance to accept “handouts,” and a hesitation to express our needs, all of which are deeply embedded within our cultures. As a result, the needs of our communities tend to be overlooked—and go unaddressed. This raises serious concerns about the future health status of AAPI communities, especially since AAPI populations are a rapidly emerging

population with the fastest rate of growth among all racial groups in the United States. In spite of their growth and their contributions to society, some policymakers and various segments of the private sector may not adequately recognize AAPI communities.

The fact is that AAPIs *do* have needs. While some AAPI families enjoy good health, others do not. While some AAPI families have ready access to the full range of health care resources they need, others do not. And while some AAPI families have access to basic information on health promotion and disease prevention, others do not. Indeed, much more must be done to ensure that all AAPI families are equipped with the knowledge and resources they need to live happy, healthy, and productive lives.

The **first step** toward honoring our responsibility to AAPI communities is to recognize the cultural and socioeconomic diversity within these communities. Until recently, AAPI populations generally have been categorized as a homogenous cultural group that shares similar cultural values and norms. This is not so. The term “Asian American” includes people of diverse ethnicities. Although each Asian American community is unique, they all share one common thread—an unwavering respect for the traditions, language, and customs that define their culture.

Asian American communities in the United States have experienced unprecedented growth over the past few decades, largely fueled by exponential increases in immigration from Asian countries to the United States. More than half (51 percent)

of Asian Americans live in the States of California, New York, and Hawaii; however, virtually every State has seen substantial growth in its Asian American population.

Leslie Hsu's parents came to the United States to pursue their graduate studies and achieve their American dream. Her mother and father loved Leslie and her brother very much and made many sacrifices to provide their children with love, health care, education, and faith. Leslie's parents also were very protective of their children because they nearly lost her brother, John, when he was born.

The near-death experience of Leslie's brother brought the family very close together. Each summer, the family would travel to one of the country's national parks to appreciate the beauty of nature. Having taken their kids to almost all the national parks in the United States and Canada, Leslie's parents felt that America was truly a land of opportunity.

One day without any warning, John, then 18, awoke with severe pain in his abdomen. The doctor explained that both John and Leslie's mother were hepatitis B carriers and that John had liver cancer. A year later, John passed away. One month after his death, Leslie's mother was diagnosed with liver cancer. She died the following year. Leslie was only a junior in college.

Learning that their deaths could've been easily prevented by the knowledge that Asians are at high risk for hepatitis B and that there is a safe and effective vaccine, Leslie channeled her grief toward raising awareness about hepatitis B by empowering communities to take action in health prevention, developing culturally responsive campaigns, and providing access to free screenings and vaccinations.

Asian American subpopulations, have embraced American culture, others such as the elderly often hold fast to their cultural traditions and norms. As we take steps to meet the health care needs of Asian American communities, we must consider these realities, recognize the barriers, and implement culturally responsive solutions that will safeguard the health of Asian American children and families.

The term "Native Hawaiian and Other Pacific Islander" (NHOPI) embraces Native Hawaiians who live in Hawaii and on the U.S. mainland as well as native people who live in U.S.-associated Pacific Island jurisdictions such as American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau.

Although NHOPI populations typically are classified under the umbrella of AAPIs, the fact is that these communities experience a dramatically different range of health

Many new immigrants have difficulty overcoming language barriers, and many are reluctant to access public-sector resources. At the same time, we must confront the stereotypes of our Asian American communities. While some Asian Americans enjoy economic prosperity, others live in poverty. While many Asian Americans, particularly youth in certain

disparities from their Asian American counterparts. Too often, urgent NHOPI health concerns go unaddressed because health programs designed for AAPI populations are not responsive to the unique cultural perspectives of NHOPI communities. These health concerns must be examined independently of Asian American health concerns, and health

improvement strategies targeting NHOPI communities must be developed and implemented independent of similar initiatives targeting Asian American communities.

The **second step** toward honoring our responsibility to AAPI communities is to recognize the barriers that often prevent these populations from enjoying their fundamental right to good health. Many AAPIs lack access to a reliable and routine source of health care. Cardiovascular disease, certain forms of cancer, diabetes, hepatitis, tuberculosis, and other preventable diseases disproportionately affect many AAPI subpopulations; yet, very few interventions are designed for and targeted to these very populations. Too little is known about the mental health and substance abuse treatment needs of AAPI communities, the prevalence of co-occurring mental and addictive disorders, and culturally responsive strategies for preventing substance abuse in AAPI communities, particularly among youth.

The paucity of data about AAPI health needs and a lack of understanding as to why certain diseases are more prevalent among certain AAPI subpopulations than others inhibit the development and implementation of evidence-based, culturally competent approaches to improving the health of AAPI families. Although many racial and ethnic minority groups benefit from institutions and other organizations that receive special designation and funding to meet their needs, no such designation exists for AAPI-serving institutions. Without such designation, the process of capacity building slows, and AAPI communities are

unable to develop systematic and scalable strategies for improving the health and quality of life of AAPIs.

The **third step** is to realize that the health status of AAPI families is closely linked to the knowledge, attitudes, and practices of the community. The environment in which AAPIs live, work, play, and worship can have an enormous impact on the health of individuals. Cultural values and norms play an important part in how good health is perceived, sought, and achieved. Likewise, the knowledge, attitudes, and practices of everyone who lives in the community can affect the broader health of the community. Not all AAPI communities possess the level of knowledge and resources necessary to reduce unhealthy behaviors and improve their health status.

We must ensure that each AAPI family in the United States—regardless of cultural beliefs, geographic location, or socioeconomic status—has the opportunity to be a healthy family. We must move beyond employing conventional approaches to improving health by implementing multidimensional, multitiered initiatives that reflect the powerful roles of culture and community in the health of AAPI families.

The **fourth step** is to raise awareness and sensitize the Nation about the unique needs of AAPI individuals who are most vulnerable to poor health status—the elderly, new immigrants, refugees, and children. Most Americans are unaware of the cultural and social barriers faced by AAPI individuals and families. Many AAPI seniors live in substandard housing, have little or no health insurance, or have

limited transportation to health care services. New immigrants and refugees often lack the necessary language skills to find jobs and achieve economic success in a new country. Recommended childhood immunization rates for hepatitis B vaccine among AAPI children continue to fall short of national targets (see chapter 2), putting these young people at risk for poor health outcomes that could have been prevented. Any number or combination of factors can jeopardize the health of these vulnerable groups. Our Nation must make every effort to ensure that all AAPI individuals have the knowledge, skills, and resources to live happy, healthy, and productive lives.

The **fifth step** toward honoring our responsibility to AAPI communities is to design AAPI-specific programs that are culturally appropriate, easily accessible, and responsive to the needs of the target audiences. Given the diversity of AAPI communities, we must identify new, innovative, and multicultural approaches to developing health messages and education campaigns that are tailored to AAPI subpopulations. We have to identify smarter ways to ensure that the target audiences hear and understand key prevention and health messages.

We must increase the number of health care providers and public health workers of AAPI heritage, encouraging these professionals to serve in AAPI communities where culturally relevant health care and social services are scarce and to assume an active role in promoting health awareness among their patients. We must ensure that AAPIs are active participants in the design, implementation, and evaluation of programs targeted to their communities

so we can measure our success and share the results with others.

Meeting the needs of AAPI populations requires a holistic approach that recognizes the richness of our diverse cultures and the strengths that define us. At the same time, a holistic approach must be informed by the real world in which AAPI communities live. Some AAPI families do live in poverty, lack affordable and safe housing, have no health insurance, or are unable to communicate effectively with health care providers. Efforts to improve the health of AAPI families will fail if these realities are ignored. Consequently, we need to identify holistic, culturally appropriate strategies that build on each community's unique strengths and address real-world challenges so that no child, no elder, and no family are left behind.

To meet the challenge before us, we must work together to cultivate meaningful public-private partnerships at the national, regional, State, and community levels. Together, Government agencies, businesses, private foundations, grassroots and civic organizations, social service agencies, faith-based groups, families, and individuals can tackle issues of mutual concern and outline an agenda for research, prevention, treatment, and infrastructure development that is focused on the health needs of AAPI communities. We all share the responsibility, and we all must do our part. Most important, we all must work together to ensure that our AAPI communities have the knowledge, resources, and tools they need to enjoy good health and to realize the promise of the American dream.

On behalf of the President's Advisory Commission on Asian Americans and Pacific Islanders, we applaud the President's leadership and compassion in recognizing that AAPI families are an integral part of American society and that investing in our health constitutes a critical

and urgently needed investment in this great Nation. It has been our honor and privilege to serve on this Commission, and it is with tremendous pride and humility that we present this landmark report—a report developed *by* AAPI communities *for* AAPI communities.

Executive Summary

Asian Americans and Pacific Islanders (AAPIs) encompass many diverse populations that have made critically important contributions to American life. AAPI communities often are stereotyped as a “model minority” that generally enjoys superior health status. In reality, AAPI individuals and families experience genuine health disparities. Consider these facts:

- Cancer and cardiovascular disease are the two leading causes of death for AAPIs in the United States. Growing evidence suggests that some AAPI subpopulations are disproportionately at risk for morbidity and mortality from cancer and cardiovascular disease.
- Compared to other ethnic groups, AAPI women in the United States have the lowest rates of cancer screening and are usually diagnosed at a later stage of cancer.
- Native Hawaiians are disproportionately affected by diabetes. Obesity, food intake habits, and sedentary lifestyles put Native Hawaiians and other AAPI subgroups at increased risk for diabetes.
- AAPIs account for over half of the 1.3 million chronic hepatitis B cases and half of the deaths resulting from chronic hepatitis B infection in the United States. AAPIs are 3 to 13 times more likely to die from liver cancer than Caucasians, with Chinese Americans at 6 times higher risk, Korean Americans at 8 times, and Vietnamese Americans at 13 times.
- AAPIs have a higher prevalence of tuberculosis than all other racial and ethnic groups. Asian Americans accounted for 20 percent of all cases in 1999.
- Reported infant mortality rates among certain Pacific Islander subpopulations are three to eight times higher than the national infant mortality rate.
- Many AAPIs have difficulty accessing culturally appropriate mental health care.
- Admissions among AAPI adults for substance abuse treatment increased by 37 percent between 1994 and 1999.
- A recent study of youth tobacco behaviors found that Asian American youth in 7th through 12th grades have the highest increase in smoking rates of any racial and ethnic group.
- Several States have reported alarming trends in domestic violence within AAPI communities.
- AAPIs are more likely to be diagnosed at an advanced stage of HIV disease and to be suffering from opportunistic infections at the time of diagnosis.
- Asian American elders experience language and cultural barriers that make them less likely to receive social services and medical care, and to benefit from social interaction. Asian American elders also are more likely to live in poverty than their counterparts in the general population.
- AAPIs with disabilities may experience systemic, cultural, and language barriers that prevent them from obtaining jobs,

accessing health care, and living independently in the community.

AAPI communities commonly have been regarded as a single, homogenous group when in fact AAPI subpopulations have distinct languages, cultures, histories, and socioeconomic environments. Some AAPI subgroups are linguistically isolated and poor, with low rates of educational attainment and little or no access to health care. These factors, or this combination of factors, play a powerful role in the health status of AAPI subpopulations.

How do we address these challenges? The best place to start is to develop a comprehensive and strategic health improvement plan that reflects the diversity of AAPI communities and builds on their unique cultural strengths. In addition to developing culturally tailored, holistic, strengths-based approaches to reducing AAPI health disparities, new efforts are needed to promote capacity-building and infrastructure development in AAPI communities, as well as new investments in AAPI research and data collection. At the most basic level, AAPI communities need resources, technical assistance, and training to help build organizations and service networks that maximize limited health care resources, minimize duplication of effort, and implement a coordinated community response to local health care challenges. Health care providers of all disciplines must increase their understanding of how AAPI subgroups view health and the cultural barriers that can inhibit health promotion and disease prevention. Perhaps most important, more must be done to increase access to health care for AAPI

children and families and to ensure that AAPI-owned small businesses have affordable solutions to provide health insurance to their employees and their families.

Simply put, the need to make the health of AAPI communities a public health priority has never been more urgent.

AAPI communities often are referred to as “hard to reach,” when in fact they are “hardly reached.” Health promotion and disease prevention messages are rarely targeted to AAPI populations in linguistically and culturally appropriate ways. Instead, health promotion, disease prevention, and treatment services must be culturally tailored to reflect the cultural expectations of AAPI communities. AAPIs themselves are most qualified to advise policymakers and program planners on strategies to address linguistic isolation, cultural misperceptions, insufficient health care access, the lack of knowledge about health-positive behaviors, and cultural competence in the health care setting.

The best way to ensure that prevention messages and treatment programs are culturally appropriate is to involve AAPI communities in the conceptualization, development, implementation, and evaluation of public education and service delivery programs. When health promotion and disease prevention messages are built on the cultural strengths and beliefs of the targeted AAPI community, they are more likely to be adopted by the target audience, integrated into daily life, and celebrated by the broader community. Health promotion and disease prevention messages targeting AAPI populations must be disseminated through channels and intermediary

organizations that AAPIs view as trusted and reliable sources of information.

AAPI individuals and families have an important role in improving their health status. Individual health is largely inseparable from community health. The knowledge, attitudes, and practices of the community can have a profound effect on individual health. Likewise, AAPI individuals can play an important role in promoting behavior change and health-positive behaviors in the larger community.

RECOMMENDATIONS

The following recommendations reflect the findings from the many site visits and town hall meetings that became the consensus of the President's Advisory Commission on Asian Americans and Pacific Islanders (see appendix). These recommendations are offered as practical steps to improve the health status and well-being of AAPI communities.

Recommendation: Create the Asian American and Pacific Islander Health Service.

The Federal Government should consider establishing the Asian American and Pacific Islander Health Service (AAPIHS). The AAPIHS could:

- Improve the coordination of existing Federal health programs targeting AAPI communities
- Partner with private-sector organizations and advocacy groups to develop a strategic plan to map a health improvement agenda for AAPI communities that encompasses

increasing access to health care for AAPI populations; collecting AAPI data; enhancing health care infrastructure; capacity-building in AAPI communities; providing technical assistance and training to AAPI-serving organizations; improving cultural competency among health care providers; and developing culturally tailored, holistic, and strengths-based approaches to reducing AAPI health disparities

- Cultivate public-private partnerships to implement public health policies, conduct research, and address AAPI health concerns
- Establish local AAPI-focused networks to maximize health care resources at community levels, especially in the areas of infrastructure development and capacity-building
- Promote a unified agenda for health improvement that reflects the diversity and input of AAPI subpopulations.

A key activity of the AAPIHS could be a National Resource Center on AAPI Health. The resource center could provide information, resources, technical assistance, and training to organizations serving AAPI communities; develop health promotion and disease prevention materials for distribution to AAPI audiences; adapt health promotion and disease prevention messages for diverse AAPI populations; disseminate information about AAPI-specific resources at the national, State, and community levels; and broker technical assistance and training for organizations that serve AAPI communities. In addition, the resource center could play an important role in

identifying successful health promotion, disease prevention, and service delivery models, and cultivating public-private partnerships to address key AAPI health disparities.

Recommendation: Implement and Enforce the Revised Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting.

The Office of Management and Budget's revised Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity—which mandated the separation of “Asian Americans” from “Native Hawaiians and Other Pacific Islanders” in Federal data collection and reporting by January 1, 2003—must be implemented and enforced by all Federal agencies. Full implementation of these standards will represent a major step forward in increasing our understanding of the diversity within AAPI communities and informing strategies to identify and eliminate AAPI health disparities. At the same time, these data should be collected and reported by specific AAPI groups to produce disaggregated data on AAPI subpopulations.

Recommendation: Increase Access to Public-Sector Health Insurance Programs.

Additional efforts are needed to increase access to health care for AAPI populations by improving access to public-sector health insurance programs such as Medicare and Medicaid. In addition, innovative methods such as association

health plans, health accounts, and other creative approaches to health care financing are needed to create affordable health care coverage solutions for AAPI-owned small businesses and employees.

Recommendation: Improve Cultural Competency in Health Care Settings.

More AAPI health care providers, especially those representing AAPI subpopulations that are traditionally underrepresented in the health care workforce, are needed to enhance cultural competency in health care settings. In addition, AAPI health care providers should be encouraged to “give back” to their communities by practicing in AAPI communities.

Recommendation: Support New Research, Health Education, and Public Awareness Efforts.

The research community should support population-based research to better understand the health knowledge, attitudes, and practices of AAPI communities. Such research will shed new light on barriers to care, effective interventions, and models that merit replication in other AAPI communities. In addition, philanthropic organizations should support AAPI-focused research efforts, as well as health education and public awareness initiatives to promote health, prevent disease, and improve quality of life in AAPI communities.

Recommendation: Recognize AAPI-Serving Institutions.

The Federal Government should afford community service organizations the opportunity to be officially classified as AAPI-serving institutions. Organizations serving other racial/ethnic groups have received such a designation, but these opportunities currently are not available to organizations that serve AAPI populations.

Recommendation: Involve AAPI Populations in Policymaking and Program Development.

AAPI populations should be actively involved in the conceptualization,

development, implementation, and evaluation of strategic planning for health care. This is especially critical for policies and programs that are intended to address key AAPI health concerns.

Recommendation: Emphasize a Holistic, Strengths-Based Approach to Service Delivery.

Interventions and programs targeting AAPI populations should be culturally tailored, holistic, and strengths-based. In addition, interventions and programs should be multidimensional, multilingual, and multicultural in nature.

Introduction

On June 6, 2001, President George W. Bush signed Executive Order 13216 to increase opportunities for and improve the quality of life of the 13 million Asian Americans and Pacific Islanders (AAPIs) living in the United States and the U.S.-associated Pacific Island jurisdictions. Through this Executive Order, the Bush Administration underscored its commitment to increase economic and social opportunities for AAPI populations.

The President's Advisory Commission on Asian Americans and Pacific Islanders comprises national leaders from the AAPI communities, appointed by President Bush, who represent a diverse array of fields, including health, education, economic and community development, labor, transportation, civil rights, and business.

The Commission is charged with the task of providing recommendations to President Bush for:

- Improving the quality of life for AAPIs through increased participation in Government programs in which they may be underserved, including health, human services, education, housing, labor, transportation, and economic and community development
- Fostering new research and data collection for AAPI populations
- Increasing Government, private-sector, and community involvement in improving the health and well-being of AAPIs in the United States and U.S. territories and jurisdictions.

Executive Order 13216 also sustained the work of the Federal Interagency Working

Group on Asian Americans and Pacific Islanders (IWG). Chaired by the Deputy Secretary of Health and Human Services, the IWG comprises senior-level officials in the Federal Government who are responsible for mobilizing Federal resources to address the unmet needs of AAPI populations. In 2002, the IWG developed a comprehensive inventory of existing programs and funding levels targeted to AAPIs, as well as annual implementation plans for each fiscal year.

The Office of the White House Initiative on Asian Americans and Pacific Islanders coordinates the activities of both the Commission and the IWG. The Office is housed in the Immediate Office of the Secretary, U.S. Department of Health and Human Services (HHS). HHS is the lead Federal department responsible for implementing the Executive Order.

MEMBERS OF THE PRESIDENT'S ADVISORY COMMISSION ON ASIAN AMERICANS AND PACIFIC ISLANDERS

Underscoring the Administration's unswerving commitment to addressing the needs of AAPI communities, President Bush appointed a diverse and distinguished team of national leaders to advise him on how his Administration and the Nation should address the unmet needs of AAPI communities.

John B. Tsu, LL.B, Ph.D., of Millbrae, California, is the Commission chair. Dr. Tsu is currently a regent for John F. Kennedy University in Orinda, California. He is a

life-long educator serving as classroom professor, department chair, institute director, research scholar, and branch university president at Seton Hall University, the University of San Francisco, the Hoover Institute, Stanford University, and John F. Kennedy University. In 1989, President George H.W. Bush appointed Dr. Tsu as co-chair of his Presidential Personnel Advisory Committee. Born in Jilin Province of China, Dr. Tsu was educated in Japan and received his LL.B. degree from Tokyo University. He came to the United States in 1950 to pursue graduate studies, and he received an M.A. from Georgetown University and a Ph.D. from Fordham University.

Lupo T. Carlota, M.D., of Lakeland, Tennessee, is an authority on modern scientific acupuncture. He is the president and founder of the Medical Acupuncture Research Institute of America. Dr. Carlota perfected the meridian regulatory acupuncture (MRA) system of therapy—a modern scientific approach to acupuncture now used by mainstream physicians across the United States and overseas. Distinguished for simplifying the study and practice of acupuncture for Western-trained physicians, he is credited for postulating the Quantum Theory of Acupuncture in 1976, explaining for the first time how acupuncture works from a scientific perspective. In 1983, Dr. Carlota became the first westerner invited to lecture on the science of acupuncture and its practical applications at the medical centers of Beijing, Nanjing, and Shanghai. He has served as president of several organizations, including the Association of Philippine Physicians in America, the National Filipino American Council, and the

Filipino American Empowerment Movement. He has received numerous city, State, and international citations for his professional and humanitarian works. In 1993, the governor of Tennessee awarded Dr. Carlota Tennessee's Outstanding Achievement Award in recognition of services performed so as to preserve and enhance the tradition of Tennessee excellence. In that same year, he was elected vice mayor of the city of Lakeland and served on the city's board of commissioners. A board-certified acupuncturologist, Dr. Carlota currently chairs the American Board of Acupuncture Medicine. He earned his doctorate of medicine in 1960 meritissimus (highest honors) from the University of Santo Tomas in Manila.

Amanullah Khan, M.D., Ph.D., of Dallas, Texas, is a leading, private practice physician in the fields of hematology, oncology, and clinical immunology. He serves as president of Cancer Center Associates, a private physician group in Dallas. Dr. Khan currently holds numerous leadership positions, including memberships on the Texas Board of Health and the board of the St. Vincent's Foundation. His previous positions have included member of the Governor's Task Force on Homeland Security, member of the Texas Health Care Information Council, advisory board member for the American Association of Foreign Medical Graduates, president of the Association of Pakistani Physicians of North America, editorial board member of the *Journal of Islamic Medical Association*, and member of the Managed Care Council of the American College of Physicians. Dr. Khan is also a very active member of the community,

having served as a trustee of the St. Paul Medical Foundation, a board member of the Kindness Foundation, a member of the Dallas-Ft. Worth Airport Chaplaincy Board, and a board member of the Multi-Ethnic Heritage Foundation. His numerous awards for community service and civic participation include the Honorary Citizenship Award by the mayor of Dallas, Presidential Gold Medal awarded by the Pakistan Academy of Medical Science, and the Outstanding Contribution in Medicine awarded by the Greater Dallas Asian American Chamber of Commerce. Dr Khan has edited four books and holds a patent in monoclonal antibodies to novel melanoma-associated antigens. He received his medical training at the West Pakistan Medical School and the King Edward Medical College before receiving a Ph.D. at Baylor University.

Mary M. Ling of Toluca Lake, California, came to the United States in 1968 and has worked in a variety of fields, including public affairs and international business. Currently, she serves as an administrator for the San Gabriel Valley Medical Center. Prior to that, she was the founder of Fu-Kang International, a firm based in Taipei, Taiwan, which aids foreign investors, primarily from Hong Kong and Taiwan, to invest in small businesses in the United States. She served as the firm's president from 1995 to 1999. Before that, she served as director of public relations for the Law Offices of Hogg and Benson in Los Angeles. Ms. Ling is a member of several community groups, including the Republican Women's Federation, the Chinese Lion's Club of Los Angeles, Chinese Americans for Self-Empowerment, and the Taiwanese Women's Association.

She is the proud mother of two daughters: Lisa, currently with National Geographic and a former co-host of ABC Television's talk show The View, and Laura, a producer of documentary films. Ms. Ling received her B.A. degree from Christ College.

Shing-Chern (Sean) Liou of Fremont, California, is in the tours, travel and insurance, and financial services industry. Currently, he is president of Always Best Tours and Travel, which provides custom-designed, worldwide travel experiences. Prior to this, Mr. Liou was president and COO of Keylinux, Inc., a global solutions provider of enterprise storage networking systems, software, and services, as well as CEO of Hi-Tech USA, a leading, high-volume PC systems integrator and provider of Linux solutions, integrated software, and services. He is an active member of the Taiwanese American Chamber of Commerce-Northern California, a board member of the Silicon Valley Chinese American Computer Association, and the public relations director of the 2003 Chinese American Athletic Tournament. Mr. Liou received his B.A. in chemistry from the National Changhua University of Education in Taiwan and his M.S. in mathematics and computer science from the University of Massachusetts at Lowell. He emigrated from Taiwan in 1984 and became a U.S. citizen in 1994.

Barbara Marumoto of Honolulu, Hawaii, is a member of the Hawaii House of Representatives, 19th House District. She previously served on several Federal advisory boards, including the Small Business Administration's Honolulu Advisory Council, the U.S. Department of Education's Intergovernmental Advisory

Council on Education, and the U.S. Department of Defense's Advisory Committee on Women in Services. Representative Marumoto is currently president of the Women's Legislative Network of the National Conference of State Legislatures. She holds a B.A. in sociology from the University of Hawaii.

Garry K. Ong of Phoenix, Arizona, is the president of G.O. Enterprises, which operates Pan Asian restaurants in Phoenix. He is also president and CEO of Great Wall Enterprises, Ltd., a corporation that includes the Phoenix International Trading Company and Travelink International and Consulting Services. Mr. Ong was the past president of the Chinese United Association of Greater Phoenix and one of the founding members of the Chinese Restaurant Association of Arizona. He received his B.S. in marketing from Arizona State University.

Sunny K. Park of Atlanta, Georgia, is the CEO of General Building Maintenance, Inc., president of Global Sun Investments, Inc., and CEO of Hepatech Clean Room Services, Inc. He was the founder of the Good Neighboring Campaign, a movement to improve the image of Asian Americans. Mr. Park currently serves as president of the Korea America Friendship Society and serves on the board of directors for several organizations, including the Atlanta College of Art, the National Museum of Patriotism, and the Georgia Public Policy Foundation. He is also a deacon at the Community Presbyterian Church in Tucker, Georgia, and contributes columns to the *Atlanta Journal Constitution*. Mr. Park attended the Kellogg Business School at Northwestern University.

Amata Coleman Radewagen, a Samoan and Native Hawaiian of Pago Pago, American Samoa, is on the leadership staff of the fourth highest ranking member of the U.S. House of Representatives, Republican Conference Chair Deborah Pryce of Ohio. A cancer survivor, Ms. Radewagen founded the Samoan Women's Health Fund, and her organization's efforts helped to introduce mammography to American Samoa. She represents American Samoa on the National Breast Cancer Coalition. Ms. Radewagen also has served as a democracy trainer for the International Foundation for Electoral Systems and the International Republican Institute, an advisory council member of the Western Pacific Regional Fisheries Management Council, and as Washington advisor to the American Samoa Power Authority. She has a B.A. in psychology from the University of Guam.

Jhoon Rhee of McLean, Virginia, is a world-renowned martial arts instructor with more than 60 affiliated Tae Kwon Do studios in the United States and 65 in the former Soviet Union. A 10th-degree black belt, he has been inducted into the Black Belt Hall of Fame and is regarded as the "Father of Tae Kwon Do" in both the United States and the former Soviet Union. Master Rhee is the author of five books. He served as a special advisor to the President's Council on Physical Fitness and Sports from 1985 to 1988, and he served on the National Council on Vocational Education from 1988 to 1991. In March 1992, President George H.W. Bush selected Master Rhee to be the 721st "Daily Point of Light."

Michelle Eunjoo Park Steel of Palos Verdes, California, came to the United States in 1975. She has served as a member of the California World Trade Commission, the Los Angeles County Children and Family Services Commission, and the Los Angeles Airport and Fire Commissions. Ms. Park Steel currently serves as the treasurer of the Korean American Coalition. Born in Seoul, South Korea, she received a B.S. in business administration and management from Pepperdine University.

Joseph Ting of Houston, Texas, is the CEO of West Plaza Management, an investment and management company, and vice chair of Metro Bank. In 1985, he founded Unitex Bags, Inc., a manufacturing plant based in Houston. Mr. Ting is a member of the Houston Convention Center Hotel Corporation's Board of Directors, the Asia Society of Texas Advisory Board, and the Houston Taipei Sister City Board of Directors. He came to the United States in 1977 after receiving a B.A. in economics from Fu Jen Catholic University in Taiwan. Mr. Ting also has an M.B.A. from the Florida Institute of Technology.

Bao Ky N. Vu of Atlanta, Georgia, is an analyst and portfolio manager with A. Montag and Associates, a private investment firm based in Atlanta. He is currently the finance director of the Vietnamese-American Public Affairs Committee, a member of the Vietnamese Professionals Society, and a member of the National Association of Asian American Professionals, of which he helped co-found. His past affiliations include a member of the Northlake Regional Hospital's Minority Advisory Board, vice president of the Vietnamese Confederation of Georgia, and a

member of the Community Foundation of the Greater Atlanta's Working Capital Advisory Board (micro-enterprise peer lending). He received a B.S. from Georgia Tech and an M.B.A. from Georgetown University.

Zachariah P. Zachariah, M.D., of Fort Lauderdale, Florida, has been a private practice physician since 1976. He serves as the Director of Cardiology at Holy Cross Hospital, a nonprofit community hospital in Fort Lauderdale, and as a Voluntary Professor at the University of Miami School of Medicine. Presently, Dr. Zachariah holds several leadership positions including membership on the Board of Trustees of Nova Southeastern University, Vice Chairmanship of the Florida Council on Economic Education, and membership on the Advisory Council for the Pace Center for Girls. He was a member of the Florida Board of Medicine from 1988 to 1992, and chairman from 1990 to 1992, and was elected again in 2001 to serve as chairman of the board. In addition, Dr. Zachariah has served on the National Institutes of Health's National Heart, Lung, and Blood Advisory Council. He has received numerous awards for his humanitarian work, community service, advocacy on behalf of children, and his leadership in public health. In 1997, he received the Freedoms Foundation at Valley Forge "George Washington Honor Medal"; in 1998, he received the "Torch of Liberty Award" from the American Jewish Congress and was awarded the "Ellis Island Medal of Honor"; and in 2000 received the "Ellis Island American Legends Award" from the National Ethnic Coalition of Organizations Foundation, Inc. Dr. Zachariah served as a Special Private Sector Advisor to the United States Delegation to the Meeting of

the 55th Session of the World Health Assembly of the World Health Organization (WHO) held in Geneva, Switzerland, in May 2002. On January 7, 2003, he was appointed to the Florida Board of Governors by Governor Jeb Bush. He is a leading proponent of improving heart-health through education, exercise, and even financial incentives. The Heart Association recognized him by establishing the “Zachariah P. Zachariah Golden Heart Award,” of which he was the first recipient. Dr. Zachariah received his medical training from the Armed Forces Medical College in India, and did his postgraduate training in medicine at St. Joseph’s Hospital in Patterson, New Jersey.

STAFF OF THE WHITE HOUSE INITIATIVE ON ASIAN AMERICANS AND PACIFIC ISLANDERS

To ensure that the Federal Government implements the mandates of Executive Order 13216, President Bush appointed John Quoc Duong to head the White House Initiative on Asian Americans and Pacific Islanders. Mr. Duong coordinates all Federal activities under Executive Order 13216 and works with the White House and the Advisory Commission to advise the President on the needs and concerns of this population. Mr. Duong is supported by Erik Wang, commission liaison; Betty Lam, community liaison; and Angela Monsale Comeau, administrative assistant.

CHAPTER ONE



A PORTRAIT OF ASIAN AMERICAN AND PACIFIC ISLANDER POPULATIONS IN THE UNITED STATES

O V E R V I E W

Asian Americans and Pacific Islanders (AAPIs) are a diverse collection of populations and communities that make critically important contributions to American life. People of Asian heritage who now live in the United States include a varied array of peoples from Burma, Cambodia, China, Hong Kong, India, Indonesia, Japan, Korea, Laos, Macao, Malaysia, the Maldives Islands, Mongolia, Pakistan, the Philippines, Singapore, Sri Lanka, Taiwan, Thailand, Vietnam, and scores of other South Asian and Southeast Asian countries. In 1999, 27 percent of immigrants to the United States came from Asian countries; of these, about 67 percent speak a language other than English at home.

Native Hawaiians and Other Pacific Islanders are broadly categorized in three groups. *Polynesians* generally include Native Hawaiians, Samoans, Tongans, Maoris, Cook Islanders, Tahitians, and Easter Islanders. *Micronesians* generally include Marshall Islanders, Palauans, Chamorros (Guamanians and Northern Mariana Islanders), and Carolinians (both in the Caroline Islands and in the Commonwealth of the Northern Mariana Islands). *Melanesian* is a term used to categorize those commonly referred to as Fijians as well as Papua New Guineans, Solomon Islanders, and Ni-Vanuatu. While the Melanesian Islands are not trust territories or Freely Associated States, people who live on these islands are considered to be Pacific Islanders. Native Hawaiians are the largest Pacific Islander group, followed by Samoans and Chamorros, which include indigenous Guamanians.

U.S.-associated Pacific Islands comprise three Flag Territories and three Freely Associated States. The Flag Territories are American Samoa, the Territory of Guam, and the Commonwealth of the Northern Mariana Islands. The Freely Associated States comprise the Federated States of Micronesia, which include Chuuk, Kosrae, Pohnpei, and Yap; the Republic of the Marshall Islands; and the Republic of Palau.

Although AAPIs are commonly regarded as a single population group in data collection and service delivery, it is critically important to recognize that AAPI subpopulations have distinct languages, cultures, histories, and politico-economic environments. AAPI groups vary substantially in terms of linguistic isolation, culture, educational attainment, income, health care access, health-seeking behaviors, and population distribution. These factors play a powerful role in the health status of AAPI subgroups.

AAPI populations are commonly believed to be "hard to reach"; the fact is that AAPI communities are "hardly reached." Health promotion, disease prevention, and treatment services must be culturally tailored to reflect the cultural expectations of AAPI communities. The best way to ensure that prevention messages and treatment programs are culturally appropriate is to involve AAPI communities in the development, implementation, and evaluation of public education and service delivery programs.

Asian Americans and Pacific Islanders (AAPIs) are an integral part of America's social fabric. In fact, AAPIs have made important contributions to every aspect of American life—from science, technology, business, commerce, and politics to sports, entertainment, and the cultural arts. AAPI communities are a major part of what makes the United States a great place to live and raise a family.

Investing in the health, wellness, and quality of life of AAPI communities is an investment in America's future. To protect this investment, we must embrace AAPIs as a major part of what makes America great, recognize the cultural and linguistic diversity within AAPI communities, eliminate negative stereotypes, reduce linguistic isolation,* and understand that the length of residence in the United States can have a profound effect on the health status of AAPI communities.

THE DIVERSITY WITHIN AAPI COMMUNITIES

Characterizing AAPIs as a single population neither provides an accurate portrait of the diversity within AAPI communities nor sufficiently reflects the unique needs of AAPI subpopulations. The 2000 Census marked a major turning point in distinguishing Native Hawaiians and Other Pacific Islanders (NHOPIs) from the larger Asian American population. For the first time, Census respondents could designate more than one racial or ethnic

category to describe themselves. However, additional efforts are needed to further distinguish the unique health disparities experienced by subgroups of Asian Americans, Native Hawaiians, and Other Pacific Islanders.

In addition to linguistic, cultural, and racial distinctions, socioeconomic differences are equally significant. Asian Americans have higher rates of access to technology than do Pacific Islanders. For example, American Samoa still does not have access to toll-free telephone numbers. NHOPI communities rank lower than Chinese, Japanese, and Korean Americans on every measure of health, education, and standard of living used to determine assistance needs. The lack of basic statistics on health and social services collected in any systematic fashion for AAPI populations creates a misconception of the true conditions under which Asian Americans and Pacific Islanders live. In addition, the lack of disaggregated data conceals the risk factors that jeopardize the health of different AAPI subgroups.

A DEMOGRAPHIC OVERVIEW OF AAPI POPULATIONS IN THE UNITED STATES

Data from the 2000 Census show that 281.4 million people currently living in the United States, nearly 11.9 million—or 4.2 percent—identify themselves as Asian,¹ whereas 874,000 (0.3 percent) identified as

* According to the U.S. Census, a linguistically isolated household is one in which all adults (high school age and older) have some limitation in communicating in English. A household is classified as “linguistically isolated” if no household members age 14 or older speak only English, and no household members age 14 or older who speak a language other than English speak English “very well.” All the members of a linguistically isolated household are tabulated as linguistically isolated, including members under age 14 who may speak only English.

Native Hawaiian and Other Pacific Islander.² AAPIs have the fastest growth rate of all racial/ethnic groups in the United States and are expected to comprise 10 percent of the U.S. population by 2050.³ This rapid population growth has important implications for the needs of AAPI populations in the decades to come.

Asian Americans

The vast majority of Asians living in the United States reported being Asian only, whereas 1.7 million reported being Asian as well as one or more other races. Asian Americans are a diverse array of peoples from Burma, Cambodia, China, Hong Kong, India, Indonesia, Japan, Korea, Laos, Macao, Malaysia, the Maldives, Mongolia, Pakistan, the Philippines, Singapore, Sri Lanka, Taiwan, Thailand, Vietnam, and scores of other South Asian and Southeast Asian countries. In 1999, 27 percent of immigrants to the United States came from Asian countries; of these, about 67 percent speak a language other than English at home. An estimated 88 percent of Asians living in the United States were born in other countries or have a parent who was born outside the United States.⁴

Chinese Americans are the largest Asian American subgroup. According to the 2000 Census, 2.3 million people reported being Chinese only, and an additional 0.4 million reported being Chinese in combination with at least one other race or Asian group. Filipinos and Asian Indians are the next two largest specified Asian groups. Approximately 1.9 million people reported being Filipino alone and another 0.5 million reported being Filipino in combination with one or more other races or Asian groups.

Approximately 1.7 million people reported being Asian Indian only, and an additional 0.2 million reported being Asian Indian in combination with at least one other race or Asian group. Table 1-1 presents Census 2000 data for people in the United States who reported being of Asian ethnicity.

As with other populations in the United States, not all Asian Americans participate in the U.S. Census. As a result, census population data for Asian Americans are widely believed to be underreported. Estimates for underreporting of data vary, but the President's Advisory Commission on Asian Americans and Pacific Islanders suggests that the Asian American population in the United States may be 10 to 15 percent larger than census data indicate. In addition, certain Asian American subpopulations (for example, Hmong Americans) in the United States may have even higher rates of census underreporting than other Asian American populations.⁵

Approximately 75 percent of Asian Americans speak a language other than English (see table 1-2). Some 97.4 percent of Hmongs speak a language other than English, followed by Laotians (96.8 percent), Cambodians (96.0 percent), and Vietnamese (93.8 percent). Of all Asian groups, Japanese people are the least likely to speak a language other than English (44.0 percent). Linguistic isolation represents a serious and formidable barrier that prevents many Asian Americans from receiving high-quality and responsive health care.

Educational attainment varies substantially among Asian American subpopulations. Only 31 percent of Hmong Americans

completed high school or higher compared to 88 percent of Japanese Americans. For college-level education, Asian Indians have the highest attainment rates; Cambodians, Laotians, and Hmong Americans have the lowest rate of educational attainment. Without question, Asian American subpopulations span the spectrum of educational attainment.⁶

The proportion of Asian American families with three or more workers in a household is 20 percent, compared to 13 percent of the U.S. general population.⁷ Although certain Asian American populations have high rates of educational attainment, the level of education does not always result in increased earning power. Cultural and language barriers that inhibit equal access to employment opportunities, particularly for highly educated immigrants, are a primary reason for the gap between educational attainment and income.⁸

Per capita income within Asian American groups varies greatly and is substantially affected by education, acculturation, and how recently they immigrated to the United States. Recent Asian immigrants appear to be disproportionately affected by poverty. For example, 65.2 percent of Hmong Americans are foreign-born, and 63.6 percent of them live in poverty. In contrast, of the 32 percent of Japanese Americans who are foreign-born, only 7 percent live in poverty.⁹

TABLE 1-1
U.S. ASIAN POPULATION BY
DETAILED GROUP: 2000

Asian Ethnicity	Total Population in the United States (alone or in combination with other races)
Total Asian Population	11,898,828
Asian Indian	1,899,599
Bangladeshi	57,412
Bhutanese	212
Burmese	16,720
Cambodian	206,052
Chinese/Taiwanese	2,879,636
Filipino	2,364,815
Hmong	186,310
Indo Chinese	199
Indonesian	63,073
Iwo Jiman	78
Japanese	1,148,932
Korean	1,228,427
Laotian	198,203
Malaysian	18,566
Maldivian	51
Nepalese	9,399
Okinawan	10,599
Pakistani	204,309
Singaporean	2,394
Sri Lankan	24,587
Thai	150,283
Vietnamese	1,223,736
Other Asian, not specified	369,430

Source: U.S. Census Bureau, Census 2000.

TABLE 1-2
PERCENTAGE OF ASIAN AMERICANS WHO
SPEAK A LANGUAGE OTHER THAN ENGLISH

Asian Group	Percentage Who Speak a Language Other Than English
Asian Indian	77.8
Cambodian	96.0
Chinese	83.6
Filipino	68.4
Hmong	97.4
Indonesian	78.9
Japanese	44.0
Korean	81.6
Laotian	96.8
Pakistani	89.1
Taiwanese	92.4
Thai	80.1
Vietnamese	93.8

Source: U.S. Bureau of the Census. Census 2000, special tabulations.

In a study of health care quality, 21 percent of Asian Americans, or one in five Asian Americans age 18 to 64, reported having no health insurance either at the time of the survey or at any point in the past year. Among Asian Americans, Koreans (55 percent) were most likely to be uninsured followed by Vietnamese (37 percent), Asian Indians (18 percent), Chinese (16 percent), Filipinos (15 percent), and Japanese (4 percent). Among those groups, there was substantial variation in those who reported being uninsured at the time of the survey and those who reported being uninsured some time during the previous year. However, only Filipinos who currently had health insurance but had been uninsured at some

point during the past year (9 percent) exceeded the number of Filipinos who were uninsured at the time of the survey (6 percent). All other Asian groups had a larger number of currently uninsured individuals compared to those who currently had insurance but did not at some point during the previous year.¹⁰

Several studies have documented the health-seeking behaviors of Asian American elders. One study found that Chinese, Japanese, and Filipinos age 50 and older are less likely than the general population to see a physician. When asked if they had visited a

physician in the past year, 63.1 percent of Chinese women and 58 percent of Filipino men reported doing so, compared to 81.5 percent of the overall comparable population.¹¹ The Commonwealth Fund's 2001 Health Care Quality Survey revealed that 68 percent of Asian Americans report having a regular doctor, although the rates were lower among Vietnamese (59 percent) and Koreans (46 percent). In addition, Koreans (41 percent), Chinese (35 percent), Vietnamese (30 percent), and Asian Indians (28 percent) reported higher rates of difficulties in communicating with their doctors than did the total Asian population in the United States (27 percent).¹²

TABLE 1-3
NATIVE HAWAIIAN AND OTHER PACIFIC ISLANDER POPULATIONS

Detailed Native Hawaiian and Other Pacific Islander Groups	Population (alone or in any combination) *
TOTAL	874,414
Melanesian	
Fijian	13,581
Ni-Vanuatu	18
Papua New Guinean	224
Solomon Islander	25
Melanesian, not specified	315
Micronesian	
Carolinian	173
Chuukese	654
Guamanian or Chamorro	92,611
I-Kiribati	175
Kosraean	226
Mariana Islander	141
Marshallese	6,650
Palauan	3,469
Pohnpeian	700
Saipanese	475
Yapese	368
Micronesian, not specified	9,940
Polynesian	
Native Hawaiian	401,162
Samoan	133,281
Tahitian	3,313
Tokelauan	574
Tongan	36,840
Polynesian, not specified	8,796
Other Pacific Islander	174,912

Source: U.S. Census Bureau, Census 2000.

Native Hawaiians and Other Pacific Islanders

Table 1-3 presents Census 2000 data for Native Hawaiians and Other Pacific Islanders in the United States or the U.S.-associated jurisdictions.

Some 874,414 NHOPIs live in the United States. Of these, 398,835 report being NHOPi only, whereas 475,579 identify as NHOPi in combination with one or more other races. Of the 1,211,537 people living in Hawaii, 41.6 percent are Asians and 9.4 percent are NHOPIs. It is not surprising that nearly three-fourths of all Pacific Islanders live in the West, and that more than half (58 percent) live in just two States—Hawaii and California. The Pacific Islander population exceeded the U.S. level of 0.3 percent of the total population in seven States, and all of those States are located in the West—Hawaii (23 percent), Utah (1.0 percent), Alaska (0.9 percent), Nevada (0.8 percent), Washington (0.7 percent), California

* The numbers by detailed Pacific Islander groups do not add up to the total population. This is because the detailed Pacific Islander groups are tallies of the number of Pacific Islander responses rather than the number of Pacific Islander respondents. Respondents reporting several Pacific Islander groups are counted several times. For example, a respondent reporting “Samoan and Tongan” would be included in the Samoan number as well as the Tongan number.

(0.7 percent), and Oregon (0.5 percent).¹³ These data are critically important for the design, development, and implementation of health promotion and disease prevention strategies targeting NHOPI populations.

NHOPIs comprise approximately 5 percent of the AAPI population in the United States and its jurisdictions and are categorized in three broad groups. *Polynesians* generally include Native Hawaiians, Samoans, Tongans, Maoris, Cook Islanders, Tahitians, and Easter Islanders. *Micronesians* generally include Marshall Islanders, Palauans, Chamorros (Guamanians and Northern Mariana Islanders), and Carolinians (both in the Caroline Islands and in the Commonwealth of the Northern Mariana Islands). *Melanesian* is a term used to categorize those commonly referred to as Fijians as well as Papua New Guineans, Solomon Islanders, and Ni-Vanuatu. Native Hawaiians are the largest Pacific Islander group, followed by Samoans and Chamorros, which include the indigenous people of Guam.¹⁴

U.S.-associated Pacific Islands comprise three Flag Territories and three Freely Associated States. The Flag Territories are American Samoa, the Territory of Guam, and the Commonwealth of the Northern Mariana Islands. The Freely Associated States comprise the Federated States of Micronesia, which include Chuuk, Kosrae, Pohnpei, and Yap; the Republic of the Marshall Islands; and the Republic of Palau. Although Pacific Islanders are commonly regarded as a single group in data collection and service delivery, it is critically

important to recognize that each of these Territories and Freely Associated States has a distinct language, culture, history, and politico-economic environment.

Among NHOPIs age 5 and older, 25 percent speak a language other than English at home. Thirty-three percent do not speak English very well, and 11 percent are linguistically isolated. Among NHOPI communities, Tongans and Samoans have the highest proportion of persons age 5 and older who do not speak English at home (72.4 percent and 63.9 percent, respectively), and nearly 22 percent of Tongans are linguistically isolated.¹⁵

Pacific Islanders are a relatively young population. In each of the U.S.-associated Pacific Island jurisdictions, nearly half of the population is under age 19. In Micronesia, the majority of the population is under age 15. In the Marshall Islands, 57 percent of the population is under age 19, as are 44 percent in American Samoa and 36 percent in the Northern Mariana Islands.¹⁶

Educational attainment for Pacific Islanders also varies across NHOPI subgroups. In 1990, 76 percent of all NHOPIs age 25 and older graduated from high school, compared to the national average of 75 percent. Among NHOPIs, Native Hawaiians have the highest rate of high school graduation (80 percent), whereas Tongans have the lowest (64 percent). Only 11 percent of Pacific Islanders complete college,¹⁷ compared with 20 percent of the Nation as a whole.¹⁸

Demographic characteristics that affect health status include employment and income, poverty, education, and language. Only 18 percent of Pacific Islanders are employed in managerial or professional positions. The per capita income of \$10,342 is lower than the national average of \$14,143, and 17 percent of Pacific Islanders live at the poverty level, compared to 14 percent of all Asian Americans and Pacific Islanders.¹⁹ Native Hawaiians consistently have lower educational test scores than do other residents of Hawaii, are disproportionately represented among Hawaii's homeless population (33 percent), and have the most severe housing shortage of any group in the Nation. The age-adjusted death rate for Native Hawaiians is 901 per 100,000, compared to 524 for the total United States. Major causes of premature death among NHOPIs are obesity, cardiovascular diseases, cancer, and diabetes.²⁰

POPULATION DISTRIBUTION

The largest populations of Asian Americans and Pacific Islanders live in California, Hawaii, Illinois, New Jersey, New York, Texas, and Washington State.²¹ Although the AAPI population continues to increase at a rapid pace, most AAPIs choose to live in selected regions of the country. More than half of the Nation's AAPIs live on the west coast of the United States.²² Nonetheless, AAPIs live in every State, Territory, and jurisdiction throughout the country, and many communities not previously known for having a large AAPI population are experiencing a dramatic growth in the number of new AAPI residents.

In the last decade, the AAPI population grew 139 percent in the Southern and Northeastern United States, 97 percent in the Midwest, and 95 percent in the West.²³ The distribution of AAPIs in the United States should inform future strategies to meet the health care needs of these populations. These strategies should include approaches for regions and States in which most AAPIs reside as well as for those regions and States experiencing rapid AAPI population growth.

RECOGNIZING CULTURE IN POLICYMAKING, PROGRAM PLANNING, AND SERVICE DELIVERY

The diversity within AAPI populations cannot be overstated. Although this diversity is a valuable asset to American culture and should be celebrated, such broad diversity presents a broad range of challenges for policymakers, program planners, and service providers. AAPIs can be found at the extreme spectra of almost every socioeconomic indicator—from wealth to poverty, from advanced education to illiteracy, and from entrepreneurial success to marginal daily survival. AAPI families are roughly twice as likely as non-Hispanic White families to live in poverty.²⁴

The cultural values and customs within each AAPI subpopulation vary significantly. In fact, even individuals of the same ethnicity or cultural heritage may observe different values and customs. Numerous factors can affect individual knowledge, attitudes, and practices, including educational or socioeconomic status, exposure to elders within the community,

and the degree to which individuals and families have assimilated into the broader American culture, to name just a few. For example, children and grandchildren of immigrants may acquire values and customs in the United States that represent a radical departure from the values and customs of their parents.

Likewise, individuals who have achieved high educational or socioeconomic status or who have lived in the United States for many years may adopt values and norms that constitute a departure from the values and norms typically associated with people of a certain ethnicity. As a result, health care policy, program planning, and service delivery for AAPI populations must account for both the diversity of AAPI populations and the diversity within AAPI subpopulations. In many cases, effective health policy, program planning, and service delivery will require the development of multidimensional, multitiered, and multicultural approaches that reflect the cultural, educational, and socioeconomic diversity within AAPI subpopulations.

Over the years, racial and ethnic minorities, including AAPI populations, often have been characterized as “hard to reach,” largely due to the socioeconomic,

cultural, and linguistic barriers that can inhibit the communication, receipt, and understanding of critical health messages. AAPI communities are not *hard to reach*, but rather *hardly reached*. Historically, the unique challenges facing AAPI communities have not been adequately considered in developing the health policies, programs, and messages that effectively target AAPI populations. As a result, health care policy does not always reflect the health and social needs of AAPI communities, AAPI health disparities often go unattested, and health promotion and disease prevention messages often are not packaged or presented in a culturally competent manner.

One of the best ways to reduce health disparities in AAPI communities is to involve representatives of the target audience—whether they are Native Hawaiians, recent Chinese immigrants, or Japanese seniors—in policymaking, program planning, and service delivery processes. When individuals who represent the cultural values and customs of the target audience are brought to the table to share their ideas and are involved in program implementation and evaluation, the likelihood of success substantially improves.

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CHAPTER TWO



HEALTH CONCERNS AMONG ASIAN AMERICANS AND PACIFIC ISLANDERS

O V E R V I E W

Often mistakenly viewed as the "model minority," Asian American and Pacific Islander (AAPI) communities experience health disparities that jeopardize health and reduce life expectancy. Consider these facts:

- Cancer and cardiovascular disease are the two leading causes of death for AAPIs in the United States.
- Cancer is the leading cause of death for Asian American women.
- Many studies have shown that, compared to other ethnic groups, AAPI women in the United States have the lowest cancer screening rates and are usually diagnosed at a later stage of cancer.
- Native Hawaiians are disproportionately affected by diabetes. Obesity, food intake habits, and sedentary lifestyles are factors that put Native Hawaiians at increased risk for diabetes.

- AAPIs account for over half of the 1.3 million chronic hepatitis B cases and half of the deaths resulting from chronic hepatitis B infection in the United States. Hepatitis B is 25 to 75 times more common among Samoans. AAPIs are 3 to 13 times more likely to die from liver cancer than Caucasians, with Chinese Americans at 6 times higher risk, Korean Americans at 8 times, and Vietnamese Americans at 13 times.
- AAPIs have a higher prevalence of tuberculosis (TB) than all other racial and ethnic groups. Asian Americans accounted for 20 percent of all TB cases in 1999.
- Many Asian cultures stigmatize mental health problems.
- Many AAPIs have difficulty accessing culturally appropriate mental health care.
- Admissions among AAPI adults for substance abuse treatment increased by 37 percent between 1994 and 1999.
- A recent study of youth tobacco behaviors found that Asian American youth in 7th through 12th grades have the highest increase in smoking rates of any racial and ethnic group.
- Several States have reported alarming trends in domestic violence within AAPI communities.
- AAPIs are more likely to be diagnosed at an advanced stage of HIV disease and to be suffering from opportunistic infections at the time of diagnosis.
- Asian American elders experience language and cultural barriers that make them less likely to receive social services and medical care, and to benefit from social interaction. Asian American elders also are more likely to live in poverty than their counterparts in the general population.
- AAPIs with disabilities may experience systemic, cultural, and language barriers that prevent them from obtaining jobs, accessing health care, and living independently in the community.

These facts underscore the need for a stronger focus on the health of AAPI populations. However, AAPI-specific data generally are not collected in a comprehensive and systematic fashion. Although isolated, population-based studies have raised concerns about health disparities among AAPI populations, national incidence and prevalence data are needed to clarify the most important public health needs of AAPI communities.



Commissioner Bao Ky Vu (right) at Good Shepard in Atlanta.

Often viewed as a “model minority,” Asian American and Pacific Islander (AAPI) communities generally are perceived as one of the healthiest populations in the United States. This is a myth. The fact is that AAPI communities experience a wide range of health disparities that jeopardize their health. This chapter reviews existing scientific evidence summarizing the health status of AAPI populations.

CANCER

Cancer is the leading cause of death for both AAPI males and females.¹ AAPI communities experience higher death and incidence rates for certain cancers. For example, AAPIs experience the highest incidence rates of liver cancer and stomach cancer. The incidence rate for liver cancer among AAPIs is 13.8 per 100,000—a rate that is substantially higher than that for Hispanics and Latinos (7.7), American Indians and Alaska Natives (6.8), African Americans (6.2), and Whites (4.2). The incidence rate of stomach cancer among AAPI populations is 18.5 per 100,000, which also is substantially higher than the rates among African Americans (13.9), Hispanics and Latinos (12.8), American Indians and Alaska Natives (10.4), and Whites (7.9).

AAPI females have the third highest incidence rate of breast cancer per 100,000 per year (93.4), following Whites (137.0) and African Americans (120.7). Breast cancer is the most common cancer among Chinese (55.0 per 100,000), Filipina (73.1 per 100,000), Hawaiian (105.6 per 100,000), Japanese (82.3 per 100,000), and

The Vietnamese Community Health Promotion Project in San Francisco is designed to increase awareness among Vietnamese American communities of health-positive behaviors to promote health and prevent disease. The project has produced a range of collateral materials targeting providers and people throughout the Vietnamese community. The project also has sponsored community forums, established a Pap test clinic, hired lay education workers, encouraged advocacy, and provided continuing medical education opportunities for health care providers.

The National Cancer Institute’s Asian American Network for Cancer Awareness Research & Training (AANCART) project aims to (1) build a robust and sustainable infrastructure to increase cancer awareness, research, and training among Asian Americans in four targeted regions (San Francisco, Los Angeles, Seattle, and New York), where cumulatively nearly 50 percent of all Asian Americans in the United States reside; (2) establish partnerships between AANCART and other entities to promote greater accrual of Asian Americans in clinical and prevention trials and to increase training opportunities for Asian Americans; and (3) formulate and successfully implement grant-funded research to reduce the burden of cancer among Asian Americans.

Korean (28.5 per 100,000) women. Breast cancer is the most frequent cause of cancer death among Filipina women (11.9 per 100,000). Lung cancer is the most frequent cause of cancer death among Hawaiian (44.1 per 100,000), Chinese (40.1 per 100,000), and Japanese (12.9 per 100,000) women.² A case-controlled study on the effects of immigration on the risk for breast cancer among Chinese, Japanese, and Filipina women living in California showed that Asian Americans born in the West have a breast cancer rate that is 60 percent higher than those born in the country of origin. This risk doubles after a decade of residence in the West.³

Through the use of AAPI community-based organizations and media campaigns, the Centers for Medicare & Medicaid Services' AAPI Mammography Awareness Project aims to increase awareness of breast cancer and the benefits of early detection within the AAPI community. The agency contracted with AAPI community-based organizations and media organizations to provide educational workshops, conduct screenings, and broadcast radio public service announcements (PSAs) in FY 2002. Prevention messages about mammography were broadcast in major cities across the United States and were followed up with focus group testing to assess the effectiveness of these PSAs and various other outreach methods and materials. Such programs should be encouraged and continued in the years to come.

Cancer Screening

The National Cancer Institute recommends that women in their forties should be screened every 1 to 2 years with mammography. Women aged 50 and older should be screened every 1 to 2 years. Women who are at higher than average risk for breast cancer should seek expert medical advice about whether they should begin screening before age 40 and the frequency of screening.

In addition, annual Pap tests are recommended for all women for the

early detection of cervical cancer. Survival rates for cervical cancer are nearly 100 percent when it is detected in the earliest stage.

Many studies have shown that, compared to other ethnic groups, AAPI women in the United States have the lowest cancer screening rates and are usually diagnosed at a later stage of cancer. Only 58.4 percent of adult AAPI women in the United States have had a Pap test within the past 2 years, the lowest rate of screening among all racial and ethnic groups.⁸ Studies have shown that Korean, Vietnamese, and Cambodian women have low rates of cervical cancer screening.⁹⁻¹¹

Only 48.5 percent of AAPI women age 50 and older in the United States reported having a mammography or clinical breast exam in the past 2 years, the lowest rate for breast cancer screening among all racial and ethnic groups.¹² A rapidly growing body of evidence suggests that culturally appropriate outreach and treatment strategies are needed to engage AAPI women in the cancer screening

Cervical cancer is the most common cancer among Vietnamese women (43.0 per 100,000), a rate that is five times higher than for White women.⁴ In fact, some studies have found that a large number of Vietnamese women cannot correctly explain the purpose of Pap tests.⁵ Research indicates that, compared to other racial groups, Southeast Asian women tend to have more severe cases of cervical cancer because of late diagnoses. Southeast Asian women also are less likely to follow up with prescribed treatment.⁶

Lung cancer is the most common cancer among Chinese (52.1 per 100,000), Hawaiian (89.0 per 100,000), Korean (53.2 per 100,000), and Vietnamese (70.9 per 100,000) men. Lung cancer also is the most common cause of cancer death among Hawaiian (88.9 per 100,000), Japanese (32.4 per 100,000), Chinese (40.1 per 100,000), and Filipino (29.8 per 100,000) men.⁷ Prostate cancer is the most common cancer among Filipino (69.8 per 100,000) and Japanese (88.0 per 100,000) men.

process, to educate AAPI women about ways to reduce their risk for various forms of cancer, and to encourage regular screenings.¹³⁻²⁴

Very little is known about cancer screening rates among AAPI men. However, it is critical that AAPI men undergo all appropriate cancer screenings at the intervals suggested by relevant clinical guidelines.

CARDIOVASCULAR DISEASE

Heart disease is the second leading cause of death for most Asian Americans and Pacific Islanders.²⁵ Cardiovascular disease (CVD) accounts for 35 percent of all deaths for AAPI men and 36 percent of AAPI women.²⁶ In Hawaii, heart disease mortality among Native Hawaiians is 66 percent higher than the total heart disease mortality average for the State.²⁷

Native Hawaiians disproportionately suffer the burden of heart disease compared to other ethnic groups in Hawaii. In 1990, the mortality rate for heart disease for full-Hawaiians was 4.7 times higher than for “all races” and 2.5 times higher than that for part-Hawaiians; the mortality rate for part-Hawaiians was 1.9 times higher than that for “all races.” Although the mortality rate improved for “all races” between 1980 and 1990, the rate for Hawaiians worsened.²⁸

The age-adjusted death rate for Native Hawaiians is 333.4 per 100,000, making heart disease the leading cause of death for this group.²⁹ Among Native Hawaiians, the death rate from heart disease is

66 percent higher than the rate for Hawaii’s total population.³⁰ The age-adjusted death rate per 100,000 population is 340.8 for full-Hawaiians, 125.8 for part-Hawaiians, and 89.0 for non-Hawaiians.³¹

Far less is known about the prevalence of heart disease among other Pacific Islander populations. What few data exist suggest alarmingly high rates of heart disease among other Pacific Islanders. A California study found that Guamanians (Chamorros), Samoans, and the group classified as “Other Islanders” had the highest death rates from coronary heart disease in the State.³²

Data on CVD morbidity patterns among AAPI subgroups are seriously lacking. Limited population-based studies and anecdotal evidence suggest that cardiovascular risks vary greatly among AAPI subpopulations. Asian Indians in the United States reportedly have one of the highest rates of coronary artery disease (CAD) of any ethnic group studied. In a longitudinal study among health plan

The Agency for Healthcare Research and Quality funded “The Quality of Hypertension Care for Asian Americans” project. The goal of this effort is to improve hypertension care for the Hmong population in Fresno, California. The project objectives are to (1) define quality of care for hypertension from the Hmong perspective; (2) develop a hypertension quality-of-care instrument for use with Hmong patients; and (3) pilot-test the hypertension quality-of-care instrument.

The Health Resources and Services Administration funded a project at South Cove Community Health Center in Boston, which implemented a cardiovascular disease prevention intervention (WISEWOMAN) aimed at AAPI women age 40 to 64. The program involved screening, nutrition, and physical activities to prevent cardiovascular disease among women at risk.

In 2002, the Indian Health Service released consensus guidelines for the treatment of dyslipidemias in American Indians. These guidelines, designed to provide health professionals serving Indian communities with an optimal approach to CVD prevention and treatment through management of the cholesterol and triglyceride lipids, could be readily adapted for use in AAPI communities.

members in California, the risk of hospitalization for CAD among Asian Indians was more than three times the risk for Whites in analyses that controlled for other potential cofactors such as aging, body mass index, total blood cholesterol, and blood glucose. The risk was more than six times greater for Asian Indians than for Chinese individuals participating in the same study.³³

Another study found that Southeast Asian refugees who present in primary care clinics exhibit many cardiovascular risk factors.³⁴ No general conclusions regarding cardiovascular risk among AAPI populations can be made from limited and narrowly focused studies such as these. Additional data are needed to better understand the incidence and prevalence of CVD and related conditions among AAPI populations, how risk factors vary from one subpopulation to the next, and how these risk factors can be successfully mediated through culturally tailored health promotion and disease prevention efforts.

Risk factors influence or increase an individual's likelihood of developing heart disease. Although some risk factors cannot be changed, many can be modified. The key risk factors for heart disease are high blood cholesterol, high blood pressure, smoking, obesity, physical inactivity, and diabetes.

High Blood Cholesterol

Studies on blood cholesterol levels of AAPI populations are limited. One study found that adjusted mean cholesterol levels are highest among Japanese men and women compared to other AAPI populations.³⁵ Several studies have found that mean total cholesterol and low-density lipoprotein (LDL) cholesterol are lower in Asian countries than in Western countries.³⁶⁻³⁸ Native Hawaiians appear to be at risk for CVD due to high blood cholesterol levels.

The limited number of Asian Americans who have their blood cholesterol checked indicates a serious gap in prevention knowledge and access to information. Ultimately, many AAPIs are unaware of their risk for heart disease.^{39, 40}

High Blood Pressure

Compared to most racial and ethnic populations in the United States, AAPI subgroups are less likely to be aware of their high blood pressure or to be receiving treatment. In a study of Cambodian, Laotian, and Vietnamese immigrants, 94 percent did not know what blood pressure is, and 85 percent did not know how to prevent heart disease.⁴¹ Filipino Americans exhibited significantly higher levels of high blood pressure compared to other AAPI groups—levels that are similar to African Americans in the United States.⁴²

Blood pressure levels vary among Asian American subgroups, as well as by age and gender. The California Hypertension Survey revealed that the prevalence of hypertension for Japanese women age 50

and older was less than half of the corresponding rate for women of any other ethnic group in that age bracket.⁴³ However, the same study found that Filipino men and women age 50 and older had hypertension prevalence rates of 60 percent and 65 percent, respectively, compared to 47 percent of people in the same age group in the U.S. general population. Among Chinese immigrants in Boston age 60 to 96, blood pressure levels differed according to gender. In this age group, Chinese males showed a prevalence rate of 30 percent, compared to 34 percent for Chinese females.⁴⁴

Smoking

Cigarette smoking is the major cause of coronary heart disease in the United States among both men and women.⁴⁵ Aggregated 1994 and 1995 national survey data reveal that overall adult smoking prevalence was 15.3 percent for AAPIs, 18.9 percent for Hispanics, 25.9 percent for Whites, 26.5 percent for African Americans, and 39.2 percent for American Indians and Alaska Natives.⁴⁶

However, significant variations exist in smoking prevalence within diverse AAPI communities when data are disaggregated and analyzed on a regional basis. For example, the prevalence of smoking among the general California adult population is 22.2 percent (25.2 percent among males and 19.1 percent among females). In California, the rate is 21.4 percent for AAPI males and 7.8 percent for AAPI females. Among

Pacific Islanders, the smoking rates are 32.3 among Pacific Islander males and 21.4 percent among Pacific Islander females.⁴⁷

AAPI youth are at risk for negative health outcomes associated with smoking. A California study showed that smoking rates among Asian American youth have increased by as much as 50 percent.⁴⁸ A recent study of youth tobacco behaviors found that Asian American youth in 7th through 12th grades have the highest increase in smoking rates of any racial and ethnic group.⁴⁹ These studies underscore the critically important need for smoking prevention activities targeting AAPI youth.

Asian Pacific Partners for Empowerment and Leadership (APPEAL) is a national network of individuals and organizations working toward a tobacco-free AAPI community. Its achievements include convening three APPEAL Tobacco Control Leadership Summits and launching two cycles of the Creating New Mountains Leadership Program; conducting a tobacco control capacity needs assessment of more than 250 organizations; developing national policy recommendations on comprehensive tobacco control for the AAPI community; supporting local AAPI community efforts through mini-grants and technical assistance and trainings; and publishing four educational toolkits and a monograph of research articles. The project is also developing an AAPI youth leadership program. APPEAL is supported by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, the American Legacy Foundation, and the Campaign for Tobacco-Free Kids.

Martial arts action star Jackie Chan recently joined forces with the Centers for Disease Control and Prevention and the American Cancer Society to launch the "Don't Start. Be Free! Strike Back Against Tobacco With Jackie Chan!" campaign. The campaign is part of a larger effort encouraging celebrities to speak out against tobacco use.

Obesity

Overweight is defined as a body mass index (BMI) of 25 to 29.9 kg/m². Obesity generally is defined as a BMI of 30.⁵⁰ However, special definitions of overweight have been defined for Asians (BMI of 25) and Pacific Islanders (BMI of 32).⁵¹

Length of residence in the United States appears to have an effect on obesity for some AAPI groups. Among Korean men, obesity is positively correlated with their length of residence in the United States. For Korean women, however, the relationship is not as strong.⁵² Another study found that affluent Korean men tend to be more obese than the less affluent, although affluent Korean women tend to be leaner.⁵³ In California, U.S.-born men of Chinese, Filipino, Japanese, and other Asian heritage were more obese than their ethnic counterparts in their homelands.⁵⁴

Samoans and Native Hawaiians have some of the highest rates of overweight and obesity in the world. Native Hawaiian men and women are reported to have an average BMI of 31 and 30, respectively.⁵⁵ Samoans age 20 and older, regardless of where they live, consistently show high levels of obesity. Western Samoans have an average BMI of 26 for men and 28 for women. Hawaiian Samoans have an average BMI of 31 for men and 33 for women. California Samoans show an average BMI of 35 for men and 34 for women. American Samoans have an average BMI of 30 for men and 33 for women.⁵⁶

The prevalence of overweight and obesity in the Native Hawaiian population is alarming. The mean BMI for Native Hawaiian women is 30.0, compared to 30.9 for Native Hawaiian men.⁵⁷ Thirty percent of Hawaiians age 45 to 54 are overweight.⁵⁸ In 1990, 42 percent of Native Hawaiians were reported to be overweight—a number that increased to more than 43 percent in 1992. The prevalence of overweight for the total population in Hawaii was 21.5 in 1990 and 24.9 in 1992.⁵⁹ In the Moloka'i Heart Study, 64 percent of Hawaiian participants were obese.⁶⁰

New evidence suggests that obesity can increase one's risk for cancer. The study found that, among both men and women, high BMI also was significantly associated with higher rates of death due to cancer of the esophagus, colon and rectum, liver, gallbladder, pancreas, and kidney. High BMI also was associated with death due to non-Hodgkin's lymphoma and multiple myeloma. Significant trends of increasing risk with higher BMI values were observed

A national campaign to promote regular physical activity among AAPIs could be based on the core messages of *HealthierUS*, the President's health and fitness initiative: (1) be physically active every day, (2) eat a nutritious diet, (3) get preventive screenings, and (4) make healthy choices such as avoiding alcohol, tobacco, and other drugs.

These messages could be adapted for AAPI populations and disseminated in different languages through intermediary organizations that have a vested interest in the health and well-being of AAPI communities. In fact, campaign planners may find that encouraging AAPIs to walk, practice Tai Chi, or participate in cultural dances or exercise programs sponsored by community organizations may be readily embraced by certain groups within AAPI communities.

for death from cancers of the stomach and prostate in men and for death from cancers of the breast, uterus, cervix, and ovary in women. The study suggested that current patterns of overweight and obesity in the United States could account for 14 percent of all deaths from cancer in men and 20 percent of those in women. These findings have important implications for AAPIs who are overweight or obese.⁶¹

Obesity disproportionately affects older people, especially women, in Micronesia. In a study in the Marshall Islands, more than half of all women were classified as overweight. In a similar study in Guam, 38.6 percent of Chamorros were classified as overweight.⁶²

Physical Inactivity

Physical activity reduces the risk for coronary heart disease, hypertension, colon cancer, diabetes, and illness in general. A physically active lifestyle also is associated with improved mental health, reduced stress, and a positive self-image. The 1995 *National Institutes of Health Consensus Statement on Physical Activity and Cardiovascular Health* recommended that individuals engage in physical activity of moderate intensity for 30 minutes a day on most days of the week.⁶³

Few data are available on the physical activity and fitness habits of AAPI communities. However, limited population-based studies and anecdotal evidence suggest that AAPI populations typically are less likely than the general U.S. population to engage in physical activity. One California study showed that 40 percent of Vietnamese males and 50 percent of

Vietnamese females did not exercise, compared to 24 percent of males and 28 percent of females in the U.S. population.⁶⁴

Another study found that 31 percent of Korean Americans in Alameda County, California, do not exercise, compared to 21 percent of the total California population.⁶⁵ Another recent study found that female Asian college students had the highest rates of physical inactivity among all racial and ethnic groups.⁶⁶

The Hawaii Department of Health defines sedentary lifestyle as no physical activity or physical activity fewer than three times per week or less than 20 minutes per occasion. Using this definition, 76.3 percent of Filipinos, 57.1 percent of Japanese, and 54.7 percent of full-Hawaiians and part-Hawaiians live sedentary lifestyles. Additional data are necessary to shed more light on which segments of the Native Hawaiian population are more likely to live sedentary lifestyles. At the same time, virtually no data are available on sedentary lifestyles among other Pacific Islander populations.

DIABETES

Diabetes mellitus is a group of diseases characterized by high blood levels of



Dr. John B. Tsu exercises during a break in the community roundtable meeting.

The Office of Women's Health of the Food and Drug Administration (FDA) launched the 2002 national education campaign, "Take Time To Care . . . Diabetes" in 10 cities. FDA also partnered with national and community-based organizations to produce materials and conduct focus groups for translations in Cambodian, Chinese, Korean, Laotian, Marshallese, Samoan, Thai, Tongan, and Vietnamese.

glucose. Diabetes can be associated with a range of health problems and premature death. However, people with diabetes can take measures to reduce morbidity and mortality associated with diabetes-related conditions.

Most AAPIs with diabetes have type 2 diabetes, which usually develops in adults but can be found in children and adolescents as well. Type 2 diabetes can be managed with healthy eating, physical activity, oral diabetes medications, and/or injected insulin. A small number of AAPIs have type 1 diabetes, which usually

develops before age 20 and is managed with insulin, healthy eating, and physical activity.

Prevalence data for AAPI populations are limited. Studies have shown that, compared with Whites, some AAPI populations in the United States are at increased risk for developing type 2 diabetes. A study of Native Hawaiians in two rural communities examined the prevalence of diabetes and glucose intolerance. Results showed a 22.4-percent age-standardized prevalence of type 2 diabetes in people age 30 and older. Prevalence was highest in people age

60 to 64, who had a rate of 40 percent—four times higher than that of the non-Hispanic White population surveyed in the National Health and Nutrition Examination Survey II.⁶⁷

Analysis of data collected in Hawaii from 1996 to 2000 showed that Native Hawaiians were 2.5 times more likely to have diabetes than were non-Hispanic White residents of similar age.⁶⁸ In contrast, the prevalence of diabetes in some isolated Polynesian groups may be relatively low, although higher among women than men. Researchers attributed the rate differentials to increased physical activity among men and more sedentary lifestyles and higher calorie consumption among women. In Western Samoa, diabetes prevalence in a rural community (3.4 percent) was less than half the rate in an urban setting (7.8 percent), even after adjusting for body weight. Researchers found that rural residents exhibit significantly higher rates of physical activity than do their urban counterparts.⁶⁹

The National Diabetes Education Program (NDEP) seeks to improve diabetes management and reduce the morbidity and mortality from diabetes and its complications. The program, which represents a collaborative effort between the National Institutes of Health and the Centers for Disease Control and Prevention, consists of numerous minority workgroups, including an AAPI workgroup, which adopt national diabetes prevention messages for their respective communities.

Funded through a 3-year cooperative agreement with the Centers for Disease Control and Prevention, the Building Awareness Locally and Nationally Through Community (BALANCE) Program for Diabetes is designed to work cooperatively with the NDEP to increase diabetes awareness and improve diabetes care in AAPI communities. The BALANCE Program provided resources and technical assistance to six project sites at the Association of Asian Pacific Community Health Organizations' member community health centers to implement the NDEP in their communities. Products of the BALANCE Program include a policy position paper on diabetes, a diabetes cultural assessment from 13 AAPI communities through focus groups and key informant interviews, translated culturally appropriate press releases, a recommended list of multilingual diabetes educational materials, a media spokespersons' kit, and *Steps to Manage Your Diabetes* educational material in Chinese, Korean, Samoan, Tagalog, and Vietnamese.

Obesity is a major risk factor for type 2 diabetes among all races and ethnic groups. The degree to which obesity is a risk factor for diabetes depends on overall weight and the location of excess weight on the body. Central or upper-body obesity is a stronger risk factor for type 2 diabetes than is excess weight carried below the waist.⁷⁰ In a study comparing Japanese in Japan with Japanese Americans in Hawaii, the Hawaiian Japanese had a higher rate of obesity and twice the prevalence of type 2 diabetes.⁷¹

As a result of immigration and modernization, the food choices of subsets within AAPI populations have changed. Many AAPIs have abandoned a traditional plant- and fish-based diet and are choosing foods with more animal protein, animal fats, and processed carbohydrates. One study compared the diets of Japanese American men in Seattle to those of Japanese men in Japan. The Japanese American diet was higher in calories, protein, fat, and carbohydrates. The daily intake of fat in Japanese American men was 32.4 grams, compared to only 16.7 grams among Japanese men in Japan.⁷² Other studies have shown that the diet of many Asian Americans in the United States is higher in calories and fat and lower in fiber than the diet in their countries of origin.⁷³

Urbanization seems to have caused many AAPIs to abandon a physically active lifestyle for a more sedentary one.⁷⁴ Findings of a study of 8,000 Japanese American men living in Hawaii suggested that a traditional Japanese lifestyle was associated with a reduced prevalence of type 2 diabetes. Components of this

lifestyle include higher levels of physical activity and consumption of more carbohydrates and less fat and animal protein.⁷⁵

Diabetes Among AAPI Youth

Recent studies point to an increasing incidence of type 2 diabetes in youth, particularly among racial and ethnic minority youth. Data relevant to AAPI youth are scarce, but trends among Asian American youth may indicate future trends in the larger group.⁷⁶ Type 1 diabetes in Asian American children is relatively rare, as rates are significantly lower among Asian youth compared to non-Hispanic White youth. Data from one study suggest that environmental factors may be involved in the etiology of type 1 diabetes because rates of type 1 diabetes were higher in Japanese children in Hawaii than in Japanese children in Tokyo.⁷⁷

HEPATITIS

Compared to the U.S. average, hepatitis B is 25 to 75 times more common among Samoans and immigrants from Cambodia, China, Laos, and Vietnam.⁷⁸ Although a vaccine is available, individuals and families with limited access to preventive health maintenance services may not be vaccinated against hepatitis B. Furthermore, AAPI populations generally are not aware of the benefits of hepatitis B vaccines in helping to prevent liver cancer. Liver cancer, which is usually caused by exposure to the hepatitis B virus, disproportionately affects Asian Americans.⁷⁹

The Centers for Medicare & Medicaid Services funded the Hepatitis B Educational Campaign. This campaign was piloted by the Boston Regional Office in FY 1999 in partnership with the Hepatitis B Initiative (www.hepbinitiative.org) to serve Boston's Chinese and Vietnamese communities. In FY 2002, the Hepatitis B Campaign was expanded to include contractual relationships with community-based AAPI organizations in California, Hawaii, Illinois, and New York. This expanded educational effort informs AAPIs of their increased risk of hepatitis B and of the availability of the hepatitis B vaccine through Medicare and Medicaid. Activities conducted in FY 2002 included the use of focus group testing to develop linguistically and culturally appropriate educational materials targeted to AAPI populations.

More than 40 health and human service organizations and concerned individuals in the San Francisco area joined forces to address high rates of hepatitis B in the city's Chinese community. Major accomplishments of this public-private partnership, called the NICOS Chinese Health Coalition, include:

- Providing one-on-one education to more than 200 at-risk Chinese Americans via information workshops at community health fairs, neighborhood agencies, and local clinics
- Providing hepatitis B screenings and followup information to 577 people in the community, of which 48 clients tested positive and received followup care
- Conducting hepatitis B education and awareness activities for more than 170 local providers
- Bringing together 20 physicians to develop culturally tailored clinical guidelines that outline a treatment protocol for hepatitis B in the Chinese community.

The Asian Liver Center at Stanford University is a nonprofit organization in the United States founded to address the high incidence of hepatitis B and liver cancer in Asian Americans. The Center spearheads education outreach and advocacy efforts in the prevention and treatment of hepatitis B and liver cancer, serves as a resource for the general public and health practitioners, and implements clinical and basic science research programs.

Asian immigrants have high rates of hepatitis C infection. In the United States, blood-to-blood contact by sharing needles for injecting drugs is the most likely mode of transmission for hepatitis C. For Asian immigrants, however, injection drug use is less common than in the general U.S. population.

The Importance of Vaccination

AAPI children in the United States have high rates of hepatitis B infection.⁸⁰ Vaccination to prevent hepatitis B has been recommended for these children since the Food and Drug Administration first licensed the vaccine in 1981.⁸¹ Vaccination series completion rates for AAPI children age 19 to 35 months increased from 39 percent in 1994 to 88 percent in 1997.⁸² However, hepatitis B vaccination coverage among older AAPI children was only 10 percent in 1995.⁸³

A 1998 population-based study conducted by the Centers for Disease Control and Prevention found that hepatitis B vaccination programs conducted specifically within AAPI communities resulted in higher vaccination rates among children than in other cities where no vaccination programs targeted AAPI children.⁸⁴ Increased efforts are needed to design successful immunization and "catch-up" campaigns for AAPI children, high school students, college students, and adults.

In 1997, Huy Ngoc Trinh, M.D., a clinical instructor of gastroenterology at Stanford University and a medical practitioner, and some of his colleagues founded *Song Manh* (wellness), a Vietnamese-language family health magazine that now reaches 10,000 households nationwide. Dr. Trinh also wrote “Benh Gan,” a 100-page, Vietnamese-language handbook on hepatitis A, B, and C.

TUBERCULOSIS

AAPIs have a higher prevalence of tuberculosis (TB) than all other racial and ethnic groups. Although TB cases among U.S.-born individuals declined steadily between 1991 and 2001, the number of cases among people born in other countries who are now living in the United States climbed slowly during the same period. In 1991, people living in the United States but born in other countries accounted for approximately one-fifth of all TB cases. In 2001, however, foreign-born individuals in the United States had roughly the same number of TB cases as those born in the United States.

Among those with TB in 2001 who were born in other countries, Mexicans were most at risk (23 percent), followed by Filipinos (12 percent), Vietnamese (8 percent), Indians (8 percent), Chinese (5 percent), and Koreans (3 percent). Some 38 percent of TB cases among foreign-born individuals in 2001 were from “other countries,” which may include many Asian countries not mentioned above.⁸⁵

Asian American communities may be at particularly high risk for TB infection. According to the National Institute of Allergy and Infectious Diseases, Asian Americans accounted for 20 percent of all TB cases in 1999.⁸⁶ In San Francisco, TB cases among Asian Americans in 1999 increased by 13.5 percent over the previous year, bringing the number of

active cases in the city to more than 60 people per every 100,000—the highest rate among all ethnicities in San Francisco, compared to African Americans (40 per 100,000), Latinos (20 per 100,000), and Whites (fewer than 10 per 100,000).⁸⁷ In New York City, Asian Americans have the highest rate of TB of any broadly defined ethnic or racial group, especially among children and the elderly. In 1999, Asian Americans accounted for 24.1 percent of all TB cases in New York City.⁸⁸ In Arizona, AAPIs had the highest TB rate in 2000 (29.5 per 100,000) compared to all other racial and ethnic groups.⁸⁹

THALASSEMIA

Thalassemia is an inherited genetic disorder that affects the body’s ability to make enough hemoglobin in the blood. The two main types—alpha and beta thalassemia—are among the most common genetic diseases worldwide and have been found in individuals of almost every ancestry. Alpha thalassemia is most common in people from Southeast Asia, Malaysia, and southern China. Beta thalassemia, also known as Cooley’s anemia, is common among Indian, Chinese, and Southeast Asian (including Vietnamese, Laotian, Thai, Singaporean, Filipino, Cambodian, Malaysian, Burmese, and Indonesian) and Indo-Pakistan subcontinent populations. Due to global migration patterns, the incidence of thalassemia in North America has

increased in the last 10 years, primarily due to immigration from Southeast Asia.

Alpha thalassemia major is a very serious disease that results in severe anemia beginning even before birth. Most affected babies are born dead or die shortly after birth. *Beta thalassemia major* usually causes severe anemia that can occur within months after birth. If left untreated, severe anemia can result in insufficient growth and development, as well as other characteristic physical complications that can lead to a dramatically decreased life expectancy.

Accurate prevalence figures for thalassemia in AAPI communities are hard to obtain. This difficulty arises due to testing limitations in determining exact genetic diagnoses as well as the fact that many studies have focused on small, biased hospital populations. However, two population studies may reflect the current prevalence of thalassemia. Between 1990 and 1996, the State of California screened more than 3.1 million infants born in this multiethnic State for beta thalassemia. Approximately 1 in 114,000 infants had *beta thalassemia major*, with prevalence rates being highest among Asian Indians (about 1 in 4,000) and Southeast Asians (about 1 in 10,000).

Another type of beta thalassemia disease, E/beta thalassemia, was found in approximately 1 in 110,000 births, all of which occurred in families of Southeast Asian ancestry. Among Southeast Asians, E/beta thalassemia was seen in approximately 1 in 2,600 births. This is in keeping with the observation that hemoglobin E trait carrier rates are

relatively high within the Southeast Asian population: 16 percent in a study of 768 immigrants to California and up to 25 percent in some specific Southeast Asian populations such as Cambodians.

Although these studies address some of the limitations of earlier population studies, the pattern observed in California is expected to be different in other areas of the United States and the world. For example, Italians are underrepresented on the west coast of the United States compared to the east coast. Another study of 500 pregnant women in Northern Thailand estimated a frequency of 1 in 500 pregnancies affected by *alpha thalassemia major*.⁹⁰

MENTAL ILLNESS, SUBSTANCE ABUSE, AND CO-OCCURRING DISORDERS

Our knowledge of the mental health needs of AAPI populations is limited. National epidemiological studies have included few AAPIs who are linguistically isolated. Although overall prevalence rates of diagnosable mental illnesses among AAPIs appear similar to those of Whites, AAPIs show higher levels of depressive symptoms than do Whites when symptom scales are used. Furthermore, Chinese Americans are more likely to exhibit somatic complaints of depression than are African Americans and non-Hispanic Whites.⁹¹

Many AAPI cultures stigmatize mental health problems, and very little has been done to address stigmatizing attitudes about mental illness in AAPI communities.⁹² Common mental disorders such as depression often are equated with insanity, making it difficult for individuals with these

disorders to seek help. For AAPI adults with mental illness and AAPI children and adolescents with serious emotional disturbances, the stigma associated with mental disorders can easily result in discrimination, prejudice, and ridicule. Like the general U.S. population, new efforts are needed to educate AAPI communities that mental disorders are real and highly treatable, and that people with mental disorders often can live independently in the community as long as they have access to the services and supports they need.

Stressful life events experienced in the country of origin—from political or religious persecution to torture—increase the risk for mental disorders. Many Southeast Asian refugees are at risk for post-traumatic stress disorder (PTSD) associated with trauma experienced before and after immigration to the United States. One study found that 70 percent of Southeast Asian refugees receiving mental health care met diagnostic criteria for PTSD. In a study of Cambodian adolescents who survived Pol Pot's concentration camps, nearly half experienced PTSD and 41 percent suffered from depression 10 years after leaving Cambodia.⁹³

When older adults immigrate to the United States, they may experience stress associated with acculturation, linguistic isolation, devaluation of their status as community elders, and separation from peers, friends, and family members in their homeland. A national survey showed that Asian American children age 18 and younger were less likely than did Whites,

The Substance Abuse and Mental Health Services Administration recently awarded a 3-year, \$400,000-per-year grant to the National Asian American Pacific Islander Mental Health Association (NAAPIMHA). This project will address the lack of clinicians who are trained to provide culturally appropriate mental health services to diverse AAPI populations. NAAPIMHA will convene a group of experts to design, implement, and evaluate a core curriculum based on successful programs serving AAPI communities around the country. This curriculum will be used to train interns at the master's and doctoral level as well as psychiatric residents. Lessons learned from this process will be used to provide technical assistance to communities attempting to increase their capacity to provide culturally competent services.

Blacks, and Hispanics to receive mental health care.⁹⁴ Other national surveys have shown that 30 percent of Asian American girls in grades 5 through 12 reported more depressive symptoms than White, Black, and Hispanic girls.⁹⁵ Asian American teenage boys were more likely than their White, Black, and Hispanic peers to report physical or sexual abuse.⁹⁶

Nearly half of AAPIs have difficulty accessing mental health services because they do not speak English or cannot find services that meet their language needs. Approximately 70 AAPI providers are available for every 100,000 AAPIs in the United States, compared to 173 White providers per 100,000 Whites. No reliable information is available regarding the Asian language capabilities of mental health providers in the United States.⁹⁷

AAPIs appear to have extremely low utilization of mental health services relative to other U.S. populations. One study found that only 17 percent of AAPIs experiencing mental health problems sought care. Among AAPI populations,

severity of disturbance tends to be high, perhaps because AAPIs tend to delay seeking treatment until symptoms reach crisis proportions. Although more research is needed, shame and stigma are believed to figure prominently in the lower utilization rates of mental health services in AAPI communities. Instead, AAPIs tend to use complementary therapies at rates equal to or higher than Whites.⁹⁸

In terms of treatment response, one study found that AAPI clients had poorer short-term outcomes and less satisfaction with individual psychotherapy than did Whites. Another study found that older Chinese Americans with symptoms of depression responded to cognitive-behavioral therapy as did other multiethnic populations. AAPI clients matched with therapists of the same ethnicity are less likely to drop out of treatment than are those without an ethnic match. Preliminary studies suggest that AAPIs respond clinically to psychotropic medicines in a manner similar to Whites—but at lower average dosages. The 1999 *Surgeon General's Report on Mental Health* stated that additional research is needed to identify key components of culturally appropriate mental health services for AAPIs.⁹⁹

Suicide

In New York City in 1999, suicide was one of the 10 leading causes of death for Asian Americans of all ages, but was not a leading cause of death for any other racial group.¹⁰⁰ In 1997, suicide was the leading cause of death among Asian Indians age 15 to 24. Asian American women age 15 to 24 have a higher suicide rate than do White, Black, and Hispanic women in the

same age group.¹⁰¹ Protective factors such as social support and connectedness to others (for example, family members and community peers) appear to play significant roles in preventing suicide. One possible explanation for higher suicide rates among Asian American women is the cultural barriers associated with seeking mental health support. Although depression is common among Asian American women, it should not be regarded as the sole cause of suicide and suicidal ideation. Cultures in which counseling and psychotherapy are not socially acceptable tend to have higher rates of suicide.

Substance Abuse

Perhaps because AAPI populations are typically viewed as a “model minority,” alcohol use among AAPIs often is overlooked or completely ignored. Despite generally low drinking rates among Asian Americans, drinking behaviors vary substantially among different Asian groups. According to the Office of Applied Studies of the Substance Abuse and Mental Health Services Administration—which administers the National Household Survey on Drug Abuse, the Drug Abuse Warning Network, and the Drug and Alcohol Services Information System—Asian youth are less likely to use alcohol than are Hispanic, White, or American Indian and Alaska Native youth.

Asian youth are more likely than youth from other racial and ethnic groups to believe that their parents would strongly disapprove of their drinking one or two alcoholic beverages nearly every day. In addition, Asian youth are more likely than

youth from other racial and ethnic groups to have perceived greater risk from having five or more drinks of an alcoholic beverage once or twice a week. Yet, Filipino youth are more likely than Chinese or Asian Indian youth to have used alcohol during the past year. Interestingly, rates of binge drinking for Asian Indian and Filipino youth are similar, and both are higher than the rate for Chinese youth.¹⁰²

Admissions among AAPI adults for substance abuse treatment increased by 37 percent between 1994 and 1999. Compared to 5 percent of the total admissions, nearly 19 percent of AAPI admissions for substance abuse treatment were for stimulant abuse. In 1999, the average age at admission was younger among AAPIs (age 30) than in the total treatment population (age 33). The number of AAPI adolescents admitted for substance abuse treatment increased by 52 percent between 1994 and 1999.

About three-quarters of substance abuse treatment admissions among AAPI adolescents were first treatment episodes. AAPI adolescents were more likely to enter substance abuse treatment through self- or individual referral than were youth in the total treatment population. Among AAPI youth, females were more likely to seek treatment than males. Furthermore, marijuana was the primary substance of abuse among 49 percent of all AAPI youth who sought treatment.¹⁰³

Data related to tobacco use among AAPI populations are presented earlier in this chapter.

Co-occurring Mental and Addictive Disorders

Awareness is growing that co-occurring mental and addictive disorders represent a formidable public health challenge that jeopardizes the Nation's health. Data are emerging regarding the incidence and prevalence of co-occurring disorders among the U.S. population. However, little is known about the incidence and prevalence of co-occurring disorders among U.S. subpopulations, including AAPI communities. Additional research is needed to better understand the degree to which co-occurring disorders affect AAPI populations and the differences among AAPI subpopulations.

ALTERNATIVE MEDICINES AND THERAPIES

Many AAPI cultures highly value and widely use alternative medicines and therapies—also known as complementary medicine, herbal therapy, traditional healing, or Oriental medicine. Many of these cultures view health and illness as a continuum, and the art of ancient healing emphasizes the physical and mental balance of the whole person—body and soul. As a result, the concept of holistic medicine is deeply embedded in the psyche and health-seeking behaviors of many AAPIs.

In recent years, alternative medicines and therapies—including acupuncture, chi gong massage, ginkgo biloba, and ginseng, to name just a few—have gained some level of acceptance in Western medicine. On November 5, 1997, a National Institutes of Health panel approved the use of acupuncture; however, public-sector

programs such as Medicare and Medicaid do not cover the cost of acupuncture and other alternative therapies and medicines.

Some alternative medicines are used in combination with conventional Western medicine (for example, using aromatherapy to reduce patient discomfort after surgery). A growing body of scientific evidence points to the effectiveness of some alternative treatment modalities such as acupuncture,¹⁰⁴ and a number of traditional therapies have been a mainstay of AAPI practices of healing for centuries.¹⁰⁵ The growing presence of clinics specializing in acupuncture and manual manipulation, the increasing use of herbs, and Asians' long history of using these treatments indicate that use of alternative therapies among Asian Americans is high.¹⁰⁶

Product Safety and Potentially Harmful Interactions

Concerns over the use of alternative medicines and therapies persist, and many of these concerns are well founded. Many products used by alternative healers are largely unmonitored, and the quality of such products is not controlled. A wide range of products are available on the market as dietary supplements, but these products may be contaminated or may vary significantly in terms of content, quality, and safety.¹⁰⁷ In addition, if a product is proven safe and effective, other similar and readily available products may have different effects or should be taken at different doses.

An estimated 15 million Americans take high-dose vitamins or herbs along with prescription drugs—not knowing the risk of

adverse effects from potentially harmful interactions. The danger of such interactions is particularly high for Asian Americans.¹⁰⁸ The National Center for Complementary and Alternative Medicine at the National Institutes of Health is conducting research to examine the safety and effects of these products. Health care providers that integrate both Western medicine and traditional healing methods in the primary care setting should remain informed of these developments to ensure that prescribed treatments do not lead to disastrous side effects for patients.

Patient Use and Provider Awareness and Attitudes

Patients and health care providers may have different ideas about the effectiveness or appropriate use of alternative medicines and therapies. One study found that half of the pediatricians surveyed would consider referring patients to alternative therapies, and most expressed an interest in taking continuing medical education courses on complementary and alternative medicines.¹⁰⁹ Another study found that people who use complementary and alternative medicines believe they are effective, but their health care providers frequently are unaware that their patients are using such therapies,¹¹⁰ which raises questions about the potential for harmful drug-herb or drug-supplement interactions, especially among seniors.¹¹¹

Other studies have underscored the importance of open patient-provider communication about the use of alternative therapies.¹¹²⁻¹¹⁵ Sixty percent of medical schools in the United States now teach about alternative medicine practices.¹¹⁶ However, what medical

students are being taught about such therapies and whether students are encouraged to be sensitive to the importance of such therapies in Asian American communities remain unknown.

AAPIs stand to benefit from an integrative medicine model in a primary care setting, which combines traditional healing and Eastern therapies with Western medicine. Understanding the importance of traditional healing practices and complementary medicine is critical to delivering quality health care for AAPIs. In doing so, providers gain the trust of their patients, improve access to quality health care, and sidestep the potentially disastrous consequences that might occur when patients mix prescribed medications with traditional healing remedies.^{117, 118}

OTHER PUBLIC HEALTH CONCERNS

In addition to the major health concerns previously presented, several other public health challenges continue to put AAPI communities at risk for premature illness and death. Among these serious public health challenges are family violence, HIV/AIDS, and disabilities.

AAPI Elders

Between 1990 and 2000, the Asian American population over age 65 increased by more than 75 percent.¹¹⁹ Demographers suggest that, although all major ethnic groups anticipate increases in the number of seniors in

Health care providers should increase their awareness of alternative medicines and therapies that are common practices in AAPI communities—many of which have become popular and embraced in mainstream American culture. Insurance companies do not necessarily cover even widely accepted, results-based therapies such as acupuncture, a therapy endorsed by the National Institutes of Health on November 5, 1997. And in some cases, acupuncture represents a more cost-effective treatment than traditional Western medical approaches.

coming years, the number of AAPI elders is expected to increase at a particularly rapid rate,¹²⁰ as is the diversity of the AAPI senior population.

The challenges faced by AAPI elders are radically different than those facing seniors in the general U.S. population. Asian American elders experience language and cultural barriers that make them less likely to receive social services, medical care, and social interaction. Census data also indicate that Asian American elders are more likely to live below the Federal poverty level than are seniors in the general population. So not only do the needs of AAPI elders go unmet, but their needs actually may intensify.¹²¹

The U.S. Administration on Aging sponsors a “Community-Based Capacity-Building for Asian/Pacific Islander Elders Project” through the National Asian Pacific Center on Aging in Seattle, Washington. The project offers a series of capacity-building activities and town meetings in 10 areas with large AAPI communities. Conducted in the languages spoken by participating groups, these meetings provide information, technical assistance, capacity building, and evaluation of local service needs. Such projects promise to contribute to the growing capacity of community services.

During World War II, thousands of Filipinos were called into military service to fight under U.S. command. Although these brave soldiers were promised U.S. citizenship and veterans benefits, some recruited under the Commonwealth Army and New Scouts never received the benefits promised to them. In recent years, some steps have been taken to honor the Nation's commitment to these honorable veterans, but additional steps are needed to compensate these soldiers properly for the sacrifice and service on behalf of the United States, such as access to Veterans Administration medical services, among others.

NANAY, a Filipino word for mother, was established to do community outreach and provide services to AAPI elders in the Miami Dade County area. NANAY also reaches out to AAPI youth to try to connect the two generations. It provides health sessions, counseling, transport services, seminars, workshops, socialization, and recreational activities.

The center sees a lot of cases of AAPIs without health insurance. NANAY is not a health facility and can only provide health counseling. When the center detects cases that require further attention, it refers them to hospital emergency rooms. However, without insurance, these patients do not receive much attention at the hospitals. The center recently encountered two new clients. The first was a Filipino homeless person. The second was a person with HIV. The center found a place for them to stay and was able to arrange a medical examination for the homeless man to see why he was having difficulty breathing. The man died the day before his scheduled appointment with the doctor. The person with HIV, who also did not have insurance, never received adequate care and died as well.

members work long hours and cannot afford support services such as home health care, assisted living facilities, or other elder care options.

There is increasing recognition that Asian American elders who want to live independently in the community often lack safe and affordable housing, sufficient access to health care, social interaction, and the income necessary to meet their basic needs. Many AAPI elders immigrated to the United States and worked in low-paying jobs that did not offer retirement benefits.¹²³

Mental health problems are a serious issue for Asian American elders, and evidence suggests that dementia is more prevalent among Asian American elders than among seniors in the general population.¹²⁴ AAPI elders also may experience language barriers within their own families; heavy reliance on others for transportation; increased stress; feelings of isolation, loneliness, and inadequacy; and family discord.¹²⁵

Several solutions hold promise for improving the health status of AAPI elders, reducing their isolation, and maintaining their independence:

The fact that AAPI elders are highly regarded within traditional AAPI cultures does not necessarily mean that they receive adequate care. It is commonly—and erroneously—assumed that Asian American families care for their elders,¹²² when in fact they are not always able to provide adequate care. Many AAPI family

- Design and implement culturally appropriate programs targeting AAPI elders, such as health promotion and disease prevention programs that recognize the value of alternative therapies.

- Establish elder centers that emphasize AAPI traditions and celebrate AAPI holidays.
- Provide transportation services so AAPI elders may participate in community events.
- Provide translation services to facilitate communication with social service providers.
- Promote culturally sensitive nutrition programs such as Meals on Wheels or congregate meal sites with others in the community.
- Develop intergenerational programs that encourage interaction between AAPI elders and the youth in their communities.
- Provide congregate, home delivered meals.
- Provide respite services.
- Provide affordable senior housing.

Family Violence

No studies have sampled a large enough number of AAPI populations to estimate accurately the prevalence of partner abuse in AAPI communities. Underreporting of domestic violence perpetuates the lack of data regarding family violence in AAPI and other communities. However, various States and communities have identified alarming trends in domestic violence within AAPI communities.

In the past 15 years, more than 30 South Asian organizations have been founded in

the United States to combat domestic violence. Statistics from South Asian domestic violence organizations in other U.S. metropolitan areas reflect that one in five South Asian families experience domestic violence at some time. In 1997, the Asian Pacific Islander Domestic Violence Resource Project in Washington, D.C., found that nearly half of all battered clients spoke little or no English. In response, the project identified prevention programs, multilingual and multicultural counseling, and support groups that provide language and social transition skills as critical needs for AAPI women.

Federally supported programs such as “Meals on Wheels” and the Department of Labor’s Senior Community Service Employment Programs should be expanded so they can play an important role in meeting the needs of emerging populations such as AAPI elders.

The Western model of domestic violence intervention may not work for many AAPI women because of cultural, personal, and institutional barriers that define authority, independence, and disclosure of family problems.¹²⁶ Culturally appropriate programs to prevent or intervene in domestic violence are needed to reduce family violence in AAPI communities and to ensure that resources are available to those who are victims or perpetrators of domestic violence.

HIV/AIDS

AAPIs account for fewer than 1 percent of all AIDS cases reported in the United States. However, recent trends in the AAPI population are alarming. AAPIs are more likely to be diagnosed at an advanced stage of HIV disease¹²⁷ and to be suffering

from opportunistic infections at the time of diagnosis.¹²⁸ Culturally appropriate HIV prevention and education messages are needed to counter these trends and to ensure that AAPIs are armed with the knowledge and resources they need to prevent further transmission of HIV.

Funded through a cooperative agreement with the U.S. Department of Health and Human Services, the Capacity-Building in HIV/AIDS for Medical Providers Program (CHAMP) is designed to build the capacity of health care providers to address HIV/AIDS in underserved AAPI communities. CHAMP convened two advisory committee/grantee meetings, completed two needs assessment surveys among AAPI health centers, and developed a policy paper. Four rounds of funding have been provided for participating health centers for HIV/AIDS primary care services.

Disabilities

The needs of AAPIs with disabilities often go unmet. Through efforts such as the National Technical Assistance Center at the University of Hawaii at Manoa, awareness is increasing that people of AAPI heritage with disabilities need increased employment opportunities, culturally appropriate vocational rehabilitation and independent living services, and better access to preventive health care services and specialty medical care. Additional research is needed to better understand the unique needs of AAPIs with disabilities and to further clarify the systemic, cultural, and language barriers that prevent them from obtaining jobs, accessing health care, and living as independently as possible in the community of their choosing.

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CHAPTER THREE



STRATEGIES TO REDUCE HEALTH DISPARITIES AMONG ASIAN AMERICAN AND PACIFIC ISLANDER POPULATIONS

O V E R V I E W

Meeting the diverse and complex health care needs of Asian American and Pacific Islander (AAPI) communities will require the development of a comprehensive strategic plan of national scope and importance. This plan should encompass:

- Culturally tailored, holistic, strengths-based approaches to reducing AAPI health disparities
- New investments in AAPI research and data collection
- Capacity-building, infrastructure development, technical assistance, and training initiatives targeting AAPI communities
- Cultural competence of health care providers serving AAPI communities and appropriate distribution of AAPI providers in underserved AAPI communities

- Increased access to public-sector health care resources and innovative methods to create affordable health care coverage solutions for AAPI-owned businesses, and their employees and families
- Designation of organizations as AAPI-serving institutions.

Health promotion and disease prevention messages targeting AAPI populations must be developed in partnership with diverse AAPI communities and disseminated through channels and intermediary organizations that AAPIs view as trusted and reliable sources of information. AAPI communities should be active participants in the conceptualization, development, dissemination, and evaluation of health promotion and disease prevention messages.

AAPI communities themselves are best positioned to advise public- and private-sector health programs on strategies to (1) reduce linguistic isolation, (2) counter cultural misperceptions, (3) increase health care access, (4) enhance individual knowledge of health-positive behaviors, and (5) improve cultural competence in the health care setting. Messages developed *by* the community *for* the community are more likely to reduce cultural barriers, to yield behavior change, and to be shared with friends and family members. Furthermore, when health promotion and disease prevention messages are built on the cultural strengths and beliefs of the targeted AAPI community, they are more likely to be adopted by the target audience, integrated into daily life, and celebrated by the broader community.

AAPI populations must recognize that individual health is largely inseparable from community health. The knowledge, attitudes, and practices of the community can have a profound effect on individual health. Likewise, AAPIs can play an important role in promoting behavior change and health-positive behaviors in the larger community.



Commissioners visit AltaMed Health Center in Los Angeles.

The compelling health care needs of Asian American and Pacific Islander (AAPI) populations require a comprehensive, coordinated, community-based, and culturally competent response. Clearly, the Federal Government is best positioned to provide national leadership in ensuring that the health care needs of AAPI communities are addressed. However, national organizations, States, communities, businesses, civic and grassroots organizations, neighborhoods, and AAPI communities themselves have a role in establishing meaningful public-private partnerships to address key priorities concerning AAPI public health.

THE NEED FOR A COMPREHENSIVE PLAN TO ADDRESS AAPI HEALTH DISPARITIES

The first step toward addressing AAPI health disparities is to develop a comprehensive strategic plan to address the major health needs of diverse AAPI communities. Such a plan should outline a realistic, achievable, and sustainable action agenda driven by six fundamental principles:

- Reducing health disparities among AAPI populations will require culturally tailored, holistic approaches that build on the unique strengths of diverse AAPI communities.
- A national plan must place strong emphasis on capacity-building, infrastructure development, technical assistance, and training initiatives

The Bush Administration is committed to giving Americans the information and support they need to prevent diseases and stay healthy. For example, the President's 2003 budget included \$20 million for a Healthy Communities Innovation Initiative, a new interdisciplinary services effort that will concentrate Federal expertise on the prevention of common public health problems, including diabetes, asthma, and obesity. The purpose of the initiative is to reduce the incidence and complications of these diseases in five communities through a tightly coordinated public and private partnership among medical, social, educational, business, civic, and religious organizations.

targeting AAPI-serving institutions and AAPI communities themselves.

- New investments in AAPI-focused research and data collection are necessary to clearly define AAPI health disparities, to support the development of science-based and culturally appropriate interventions, and to promote the replication of effective AAPI service delivery models and interventions that have withstood the test of rigorous evaluation.
- Organizations and institutions that serve AAPI populations must have the opportunity to receive official designation as AAPI-serving institutions—an opportunity that has been afforded to all other major racial and ethnic groups.
- Health care providers of AAPI heritage should be encouraged to apply their unique linguistic and cultural assets in underserved AAPI communities throughout the U.S. mainland, the Hawaiian Islands, and the U.S.-associated Pacific Island jurisdictions.

- New efforts are needed to expand public-sector health care coverage for AAPIs who qualify and to develop creative and affordable health care coverage solutions for small AAPI-owned businesses and their employees.

Creating Culturally Tailored, Holistic Approaches

A strategic plan for improving the health of AAPI populations must reflect the diversity of AAPI communities. Health promotion, disease prevention, and treatment services must be adapted to address the unique cultural expectations of diverse AAPI communities. For example, smoking cessation messages targeting Japanese men will be different than those targeting Native Hawaiian women.

Tailoring health improvement messages for diverse audiences requires much more than merely translating English-language

materials into the language preferred by the target audience. For populations with low literacy—either in English or in their native language, or in both—written materials are not an effective way to communicate health promotion and disease prevention messages. In addition, written translations often use formal language that lacks the nuances necessary to communicate effectively about health and well-being. Health educators targeting such populations may want to explore other communication vehicles such as neighborhood meetings, community outreach, or key intermediary organizations that have earned the trust of the target audiences. For Pacific Islander populations, health communicators may need to partner with faith-based community organizations, respected community elders, and key community organizations to communicate health messages that can increase knowledge, change attitudes, and lead to healthier practices.

The Consolidated Health Centers Program, which includes the Community Health Centers Program, represents an important long-term solution for improving the health of AAPI populations.

Community health centers (CHCs) are a model for community capacity-building and infrastructure development. Located in the heart of the community, CHCs are governed by the community and thus owned by the community they serve. In addition, for more than 30 years, CHCs have demonstrated their ability to not only serve the community but also stimulate community development by providing sustainable local resources and training opportunities. The Bush Administration supports the expansion of the Community Health Centers Program. This expansion could include the development of new CHCs in communities with large AAPI populations and especially in the U.S.-associated Pacific Island jurisdictions, where the shortage of health care facilities and insufficient health care infrastructure and capacity cannot meet local needs.

Regardless of the nature of the message, health promotion or disease prevention programs targeting AAPI subpopulations should identify the unique strengths of the target audience and strategies for building on those strengths to change attitudes or modify behavior. Health communicators can gain a better understanding of the cultural strengths of a particular population by conducting focus groups with members of the target audience. Such focus groups can provide valuable insight into the messages that most likely will resonate with the target audience and identify

barriers that may inhibit the adoption of health improvement messages. In addition, AAPI community media—whether print or electronic—provide an ideal means to reach AAPI populations with health promotion and disease prevention messages. These media outlets provide a direct inlet to AAPI target audiences and are commonly viewed as trustworthy and reliable sources of information.

For organizations seeking to create service delivery programs for an AAPI population, representatives of the target audience must be involved in the conceptualization, design, implementation, and evaluation of program activities. AAPIs are the most qualified individuals to guide the development of programs targeting AAPI communities. At the same time, these persons can play a significant role in advising programs on strategies to enhance cultural competence, to conduct outreach to AAPI populations, and to evaluate the quality of services from an AAPI perspective.

Promoting Capacity-Building and Infrastructure Development

Critical to safeguarding the health and well-being of AAPI populations is the dire need to develop an AAPI-focused infrastructure for research, data collection, program planning, and service delivery. Leveling the playing field by officially designating qualified organizations and programs as AAPI-serving institutions would represent a sound first step toward increasing the capacity of AAPI

organizations to meet the needs of AAPI communities. However, capacity-building is a time-intensive process that requires patience, diligence, and, most important, resources.

In addition to creating sustainable funding streams, many AAPI organizations require technical assistance and training to apply their knowledge effectively and to put their ideas into action. Sadly, technical assistance and training opportunities are often inaccessible, irrelevant to the needs of AAPI populations, or only available to AAPI organizations on a sporadic basis. These factors hinder the development of community efforts to develop sustainable and culturally relevant programs and services. AAPI organizations and their staff members need technical assistance and training to overcome unanticipated barriers

The National Asian and Pacific Islander Health Information Network, supported by the HHS Office of Minority Health, uses a national online telecommunications system to disseminate information to AAPI communities. Four Community Access Points in California act as intermediaries to AAPI communities. Funds are provided to community-based organizations to conduct short-term health information-sharing activities using online technologies. A listserv offers an information and referral point for individuals and organizations that provide substance abuse and mental health services in and to the AAPI communities.

The National Information Infrastructure for Asian Americans and Pacific Islanders project has affected the communications and information dissemination capacity of the Association of Asian Pacific Community Health Organizations and its member organizations. It also has expanded linkages with Government agencies and health care facilities that serve AAPI populations. A Web site provides information on resources, current culturally and linguistically appropriate materials, and AAPI health care. Linkages provide emerging AAPI communities access to appropriate health care services and materials.

Several Federal agencies support projects to identify promising models for increasing access to care, reducing health disparities, and addressing specific public health concern.

The Bureau of Primary Health Care in the Health Resources and Services Administration supports the "Models That Work" initiative, which recognizes community health centers across the Nation that have achieved success in increasing access to care and reducing health disparities.

Likewise, each year the Substance Abuse and Mental Health Services Administration (SAMHSA) recognizes substance abuse prevention programs that have withstood the test of rigorous evaluation and merit replication in other communities. In fact, SAMHSA's Model Programs Initiative provides a central repository for information on effective and promising substance abuse prevention programs as well as resources for technical assistance and training.

AAPI communities would benefit greatly from having information about effective models for addressing key health concerns. In addition, many AAPI communities and organizations may need technical assistance and training resources to help them replicate models that have demonstrated their effectiveness.

Information about model programs targeting AAPI populations could be assembled into a resource guide, which could outline best practices for serving AAPI communities, and be applied throughout the health care delivery system. Once the resource guide is broadly disseminated throughout AAPI communities and the health care industry, AAPI-serving organizations could use this information to launch new programs or enhance existing services.

during program start-up, to recognize the importance of hiring multicultural and multilingual staff, to complete Medicare and Medicaid reimbursement forms correctly, to develop a sound program evaluation plan, and to address a host of other administrative and programmatic issues.

As more AAPI organizations learn from such technical assistance and training opportunities, they will have critically important knowledge to share with other AAPI organizations within their communities.

Understanding the procedural aspects of organizing, financing, delivering, and evaluating programs targeting AAPI communities would enable AAPI-serving institutions and faith-based organizations (such as those promoted through the White House Faith-Based and Community Initiatives) to function at optimal efficiency and, most important, to provide high-quality services to AAPI populations.

Increasing AAPI-Specific Research and Data

A critical step toward reducing AAPI health disparities is to design and implement an aggressive research agenda to better understand the needs of AAPI communities, especially AAPI subpopulations. An AAPI-targeted research agenda could shed new light on:

- Disparities experienced by various subpopulations within AAPI communities
- Culturally appropriate interventions to treat the diseases most prevalent among AAPI subgroups
- Health education messages that are consistent with the cultural perspectives of AAPI communities

- Service delivery models targeting AAPI populations that have withstood the test of rigorous evaluation
- Strategies for replicating effective, AAPI-competent service delivery models in other communities with large AAPI populations, and whenever possible, integrating those models into existing resources
- Strategies for adapting effective health education messages and service delivery models that have the potential for replication in other AAPI communities experiencing similar health disparities.

The U.S. Census expanded its operation in 2000 to generate more specific socioeconomic and geographic data on AAPI populations. This represents substantial progress, and other Federal agencies should take steps to collect more data that will shed new light on the health needs of AAPI communities and subgroups. Specific strategies to enhance the depth and breadth of AAPI-specific data include the following:

- Adding AAPI subpopulations and primary languages as demographic variables in all Federal health care survey data sets, regardless of whether or not evidence suggests that an AAPI disparity exists (for example, the National Health Interview Survey now uses the Census race and Hispanic origin question as part of the survey)

The HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE) is conducting a comprehensive, congressionally mandated study of HHS systems and practices for collecting data on race and ethnicity, including AAPIs. ASPE has contracted with the Committee on National Statistics (CNSTAT) of the National Academy of Sciences to conduct a comprehensive study of HHS data collection systems and practices relating to the collection of data on race and ethnicity. A panel of experts has been established to review current policies and practices, examine data requirements and limitations, and suggest improved methods. The panel's work includes:

- Identifying data needed to support efforts to evaluate the effects of socioeconomic status, race, and ethnicity on access to health care and on disparity in health and other social outcomes
- Assessing the effectiveness of the systems and practices of HHS and selected other Federal, State, and local agencies and the private sector in collecting and analyzing such data
- Identifying critical gaps in the data and suggesting ways in which they could be filled.

A summary will be issued in FY 2003, and the project will be completed in FY 2004.

"Organizations like Good Shepherd Services are critical facilitators for immigrant adjustment. At Good Shepherd Services, the spectrum of clients vary widely. From middle-school youths who attend their satellite after-school programs to the senior citizens who attend their English classes, all receive the care and guidance so needed for better acclimation as new citizens to this country."

--Commissioner Bao Ky Vu

- Educating researchers about the diversity within AAPI communities and the importance of distinguishing between Asian Americans, Native Hawaiians, and other Pacific Islanders—and the subpopulations within those groups

- Increasing the participation of AAPI populations in clinical trials
- Promoting an equitable allocation of Federal and private-sector funding for AAPI-specific biomedical research
- Promoting public-private partnerships to promote and support population-based research on the health challenges facing AAPI communities.

Federal health data sources offer the means to generate a wealth of data on the health status of AAPI populations. Table 3-1 presents some of the key Federal surveys and data sets that have the capacity to collect AAPI-specific data. These and nearly 170 other data sources currently monitor the Nation's progress toward achieving the 467 objectives tracked as part of the *Healthy People 2010* initiative, administered by the Office of Disease Prevention and Health Promotion, HHS.

Healthy People 2010 is designed to achieve two goals: (1) to increase the quality and years of healthy life and (2) to eliminate health disparities. However, most of these surveys and data sets cannot yield useful data for AAPI subgroups because too few AAPIs were surveyed, or they do not include disenfranchised AAPI populations such as seniors, immigrants, and linguistically isolated individuals in their samples. Consequently, it is not yet possible to measure progress toward achieving the 467 Healthy People objectives in AAPI populations. The health surveys and data sets listed in table 3-1 could one day prove to be a valuable resource for identifying AAPI health disparities and advocating for Federal funding to address those disparities.

In addition to the key data sources listed in table 3-1, philanthropic organizations, research institutes, academic institutions, and independent researchers have an opportunity to support AAPI-focused research and to provide resources to AAPI organizations. For example, a sufficient number of individuals representing AAPI subgroups should be included in research samples so that scientifically valid findings on AAPI health concerns can be generated, published, and disseminated throughout the field.

In addition, these segments of the research community can act as sentinel reporters of emerging trends within communities and inform policymakers and program planners of new trends as they occur.

Designating Organizations as AAPI-Serving Institutions

Most racial and ethnic minority groups in the United States have the opportunity to benefit from the services and supports offered by institutions and other organizations that receive special Federal designation to meet their needs. Such designation affords these populations the opportunity to create steady and reliable funding streams and to develop economic and social programs that are responsive to the unique needs of the population they serve.

AAPI communities do not have such a designation. Designating AAPI-serving institutions offers one of the best ways to cultivate the service delivery capacity and infrastructure to serve AAPI communities and promote efficient use of existing resources.

TABLE 3-1**MAJOR DATA SOURCES AND SPONSORING AGENCIES**

1999 National Worksite Health Promotion Survey	Association for Worksite Health Promotion; Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS); and William M. Mercer, Incorporated
Behavioral Risk Factor Surveillance System	National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP), Centers for Disease Control and Prevention (CDC), HHS
Continuing Survey of Food Intake by Individuals	Agricultural Research Service, U.S. Department of Agriculture
HIV/AIDS Surveillance System	National Center for HIV, STD, and TB Prevention (NCHSTP), CDC, HHS
Medical Expenditure Panel Survey	Agency for Healthcare Research and Quality, HHS, and National Center for Health Statistics (NCHS), CDC, HHS
Monitoring the Future Study (MTF)	National Institute on Drug Abuse, National Institutes of Health (NIH), HHS
National Ambulatory Medical Care Survey	NCHS, CDC, HHS
National Crime Victimization Survey	Office of Justice Programs, Bureau of Justice Statistics, U.S. Department of Justice
National Health and Nutrition Examination Survey	NCHS, CDC, HHS
National Health Interview Survey	NCHS, CDC, HHS
National Hospital Ambulatory Medical Care Survey	NCHS, CDC, HHS
National Hospital Discharge Survey	NCHS, CDC, HHS
National Household Survey on Drug Abuse	Substance Abuse and Mental Health Services Administration, HHS
National Notifiable Disease Surveillance System	Epidemiology Program Office, CDC, HHS
National Profile of Local Health Departments	National Association of County and City Health Officials, funded through a cooperative agreement with HHS and CDC
National Survey of Family Growth	NCHS, CDC, HHS
National Vital Statistics System—Mortality	NCHS, CDC, HHS
National Vital Statistics System—Natality	NCHS, CDC, HHS
School Health Policies and Programs Study	NCCDPHP, CDC, HHS
State Tobacco Activities Tracking and Evaluation System	Office on Smoking and Health (OSH), NCCDPHP, CDC, HHS
STD Surveillance System	NCHSTP, CDC, HHS
United States Renal Data System	National Institute of Diabetes and Digestive and Kidney Diseases, NIH, HHS, in collaboration with Centers for Medicare & Medicaid Services, HHS
Youth Risk Behavior Surveillance System	NCCDPHP, CDC, HHS

“For the Americans who are racial and ethnic minorities, obstacles to greater access to health care also may include culture and language. Some individuals avoid health care because they are unable to find health care providers who speak their language. Others decline care because they do not feel welcome at sites that are insensitive to their cultural norms and habits.”

Elizabeth M. Duke

Administrator

Health Resources and Services Administration

Testimony to the House Appropriations Subcommittee on

Labor, HHS, and Education

March 26, 2003

Addressing the Shortage and Inadequate Distribution of Multicultural Health Providers

Physicians and other health care providers of larger Asian American subpopulations are well represented among certain categories of health care professionals.

However, Hmong, Cambodian, Laotian, Native Hawaiian, and Pacific Islander individuals are not well represented in the health professions. Furthermore, the shortage of AAPI providers practicing in underserved AAPI communities continues.

The National Health Service Corps (NHSC) provides scholarships to medical students who in turn agree to serve, for a designated period of time, in a medically underserved area where health care resources are most scarce. Since 1970, more than 20,000 doctors, nurses, dentists, midwives, and mental health clinicians have been placed in medically underserved communities through NHSC. The President’s budget includes \$191.5 million—a \$44 million increase—to strengthen NHSC. With the increased funding, NHSC will provide scholarships or loan assistance to about 1,800 professionals practicing in underserved areas—an increase of about 560 participants.

Such a program provides an ideal opportunity to recruit AAPI health care providers who, upon graduation, can provide care in targeted AAPI communities that have a shortage of culturally competent health care providers.

In addition, the Federal Government sponsors an array of scholarship and loan repayment programs, such as the Health Career Opportunities Program, to ensure that racial and ethnic minorities are represented in the Nation’s health care workforce. These programs target future physicians, nurses, dentists, physician assistants, and other health care providers of many different disciplines.

Many AAPIs have difficulty accessing health care services. Even when they are able to access such services, the health care they receive is often inappropriate, or they may be unable to communicate effectively with health care providers because of language barriers. Many AAPIs do not seek regular health checkups or may be reluctant to discuss personal health issues with providers. These challenges are particularly evident among new immigrants, AAPI elders, and other segments of AAPI communities.

Most patients respond better to health care providers of the same racial or ethnic group and who speak their language. This is especially important for patients who are linguistically isolated and those who hold dear the cultural traditions and customs typically associated with their ethnic group. To this end, new efforts are needed to increase the number of AAPI

health care providers of all disciplines who provide care in medically underserved AAPI communities.

Not only do we need to increase the number of AAPI physicians practicing in underserved AAPI communities, but we also need additional steps to ensure cultural competence in the health care setting. For example, when patients access health care, the first person to greet them is usually the medical office receptionist. This first line of contact with patients is critically important and can set the tone for the entire health encounter. Patients must be able to communicate effectively with frontline medical staff and feel comfortable contacting this person again should they need to make future appointments.

Similarly, other health care delivery staff (for example, nurses, physician assistants, and other providers) must be able to communicate with patients, ask questions without causing discomfort or offense, and deliver health promotion and disease prevention messages in a culturally sensitive and appropriate manner.

Many AAPIs are hesitant to enroll in public-sector health care and social entitlements. Program planners must identify strategies for communicating the availability and eligibility of health and social resources to eligible patients. Also important is the need to establish formal relationships and to network with AAPI-serving organizations in the community that can provide support services, develop multilingual forms for obtaining

President Bush wants to provide better support for health care professionals working to deliver safer and more effective care. The Administration is re-directing Medicare's Quality Improvement Organization program to focus more on safety as well as quality, and to increase support for State, local, and community initiatives to improve the quality and safety of care delivered by health care providers to Medicare beneficiaries. The President also proposed an increase of \$5 million, for a total of \$60 million, to applied research and demonstration projects dedicated to eliminating medical errors and improving patient safety.

Medicare or Medicaid eligibility information, and provide referrals to AAPI-friendly resources in the community.

Clearly, improving the diversity of the health care workforce is critical to improving public health. However, it will always be possible that AAPIs will receive care from practitioners of a different culture or race. It is important to provide AAPI-specific cultural competency training for staff members in communities with sizable AAPI populations. In some cases, program planners may want to establish formal networks with AAPI organizations in the community to provide qualified

Community-based programs targeting Hispanic populations have found that hiring and training promotoras—Spanish-speaking health educators who are from the target community—can yield tremendous success. Residents are more likely to listen to people from their community, to adopt health-positive behaviors, and access the local resources available to them.

This outreach approach could be adapted for AAPI populations and implemented in communities where AAPI-specific health resources are limited. Asian Health Services in Oakland, California, has a long history of providing care that is linguistically appropriate and training providers to deliver the same type of care. The clinic has a language access and cultural program that offers translation services, health care interpretation training, and cross-cultural health care training.

The lack of comprehensive standards on culturally and linguistically appropriate services (CLAS) in health care has left organizations and providers with no clear guidance on how to provide CLAS in health care settings. In 1997, the Office of Minority Health (OMH) of HHS undertook the development of national standards to provide a much-needed alternative to the current patchwork of independently developed definitions, practices, and requirements concerning CLAS. OMH initiated a project to develop recommended national CLAS standards that would support a more consistent and comprehensive approach to cultural and linguistic competence in health care.

A comprehensive final report on the project, *National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Health Care Final Report*, was completed in March 2001. The final report describing 14 individual standards and outlining the development, methodology, and analysis undertaken to create the national standards can be found online at www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf.

translation services during health care appointments or referrals to AAPI-focused community agencies that are equipped to coordinate the support services that AAPI families may need. Surely, having AAPI senior staff may enhance cultural competency in health care organizations. However, any health care provider of any racial or ethnic group who has been properly trained and brings a multicultural awareness to his or her job is perfectly capable of providing high-quality, culturally competent health care to AAPIs.

Several steps can be taken to increase cultural competency in health care settings:

- Health care administrators must make a philosophical and organizational commitment to ensuring cultural competence at all phases of the health care organization, financing, delivery, and evaluation process.
- Community-based health care systems may want to explore creative means for promoting health and preventing disease throughout the community. For example, service programs may want to hire and train people from the community who

can conduct community outreach at local events, cultural celebrations, supermarkets, and other locations throughout the community.

- Numerous cultural competency training curricula have been developed for integration into medical school coursework. The time has come for AAPI cultural competency training to be integrated into the academic regimen in every medical school. Similarly, individuals receiving training to provide ancillary health care services such as home health care, HIV testing, or other basic services must be aware of AAPI cultures and the perspectives AAPIs may bring to the health care delivery experience.
- AAPI-specific training modules are needed so that ancillary health care providers and those already in the field can receive cultural competency training and integrate those principles into current and future practice. Whenever possible, these curricula and modules should be developed and administered in partnership with individuals of AAPI heritage.

Increasing Health Care Coverage

Like many families in the general U.S. population, AAPI families continue to be at risk for poor health outcomes because they do not have sufficient health care coverage. Without it, AAPI families may be unable to receive basic health care services, specialty care, health maintenance checkups, and information on how to prevent future disease.

In a study of health care quality, the Commonwealth Fund finds that 21 percent of Asian Americans, or one in five Asian Americans age 18 to 64, reported having no health insurance either at the time of the survey or at any point in the past year. Among Asian Americans, Koreans (55 percent) were most likely to be uninsured followed by Vietnamese (37 percent), Asian Indians (18 percent), Chinese (16 percent), Filipinos (15 percent), and Japanese (4 percent).¹

Having two or three jobs is common practice among working-class AAPIs. However, because many AAPIs work in family businesses or for other small businesses in the community, they are more likely to work for employers that do not offer health insurance. AAPI-owned small businesses often cannot afford costly premiums to provide health care coverage. Given the high poverty rates among recent immigrants, refugees, elders, and other segments of AAPI subpopulations, many AAPI workers cannot afford private health insurance. Similarly, many AAPI workers do not receive employer-sponsored health insurance, cannot afford the premiums associated with private insurance, and are not eligible for Medicaid. These individuals and families often “fall through the cracks”

within the Nation’s health care system and are left with no reliable source for routine health care services.

In recent years, a range of creative options for health care coverage have emerged to help reduce the ranks of the uninsured and to increase access to care. The Children’s Health Insurance Program (CHIP), funded by the Centers for Medicare & Medicaid Services and administered by the States, provides preventive and treatment services to U.S. children—regardless of a family’s ability to pay for care. Unfortunately, the age-old language barriers and concerns about receiving public services prevent many AAPI families from enrolling in CHIP.

Creative mechanisms for health care financing—such as association health plans and health accounts—provide more affordable alternatives for small business owners, including AAPIs, to pool their resources to provide coverage for their employees at lower premiums. Pending legislation regarding association health plans would lay the groundwork for allowing small businesses to provide better and more affordable health care coverage options for their employees by banding together to offer affordable health insurance options for their employees and families. Through the establishment of uniform Federal standards for association health plans, small employers would be able to achieve greater purchasing power, administrative efficiencies, and flexibility in benefit design. Strong Federal certification and solvency standards would assure that all health care benefits promised by the new association health plans would be there when needed. Furthermore, design and offering requirements would assure

that the associations provide consistent services to all eligible small businesses regardless of their expected medical costs.

Health accounts enable employers to offer at least a limited number of health care coverage choices for employees. Some of the coverage options that provide the greatest freedom for medical treatment also include significant out-of-pocket payments such as high deductibles or co-payments. These options are attractive for many Americans because they depend on the patients and their physicians, rather than insurance plan managers, to make treatment choices. The Bush Administration has proposed that Americans who want more control of their medical choices have the option to set up a tax-favored “health account,” which would permit them to pay out-of-pocket costs more easily. They would also allow Americans to build up an account to cover high medical costs when needed.

Some evidence suggests that traditional managed care programs may not be suitable for many racial and ethnic minority populations. A Johns Hopkins University study found that typical approaches to managed care—such as requirements to select a single primary care provider, to obtain a referral for specialty care, and to receive care only within a limited network of providers—had a more negative impact on Asian American children and parents than on any other ethnic group included in the study. As a result, Asian American children were less likely to remain in managed-care networks than were Hispanic, African American, and White children.² This finding raises questions about the ability of managed-

care programs to effectively address the needs of certain segments within AAPI populations, depending on the level of acculturation, linguistic isolation, and other cultural factors.

DEVELOPMENT AND DISSEMINATION OF PREVENTION MESSAGES TO AAPI POPULATIONS

The vast diversity within AAPI communities is one of the most critical themes of this report and has enormous implications for health promotion and disease prevention activities targeting AAPI communities. Policymakers, program planners, and health educators must remember that “one size does *not* fit all” when it comes to AAPI subpopulations. As stated previously in this report, health promotion and disease prevention messages that resonate with one segment of the AAPI population may not be as effective when communicated to another AAPI subpopulation. Such messages must be adapted to reflect the knowledge, attitudes, practices, and cultural perspectives of each subpopulation.

Whenever possible, appropriate AAPIs representing the target community should play an active role in developing health promotion and disease prevention messages, disseminating the messages throughout the community, and evaluating the effectiveness of the messages. Health promotion and disease prevention messages should be developed in the preferred language of the target audience rather than merely translated from English-language messages. In addition, the AAPI community should be actively involved in

defining and implementing health care policy in the United States to ensure that the Nation's agenda for health care policy reflects the needs of AAPI populations.

BARRIERS TO HEALTH PROMOTION AND DISEASE PREVENTION IN AAPI COMMUNITIES

Because AAPIs are a relatively young group, program planners and health educators must seize opportunities for health promotion, disease prevention, and behavior modification. Among the general population, it is widely known that the knowledge, attitudes, and practices developed early in life have a profound impact on future health. Intensive, culturally tailored efforts are needed to teach young AAPI populations about the benefits of health-positive behaviors and the risks associated with unhealthy practices such as smoking, lack of physical activity, premature sexual activity, alcohol and drug abuse, and other key public health concerns.

Public education and awareness programs that have achieved success among other key population groups in the United States have demonstrated the importance of engaging community leaders and organizations in the dissemination of health promotion and disease prevention messages.

Messages developed *by* the community *for* the community are more likely to reduce cultural barriers, to yield behavior change, and to be shared with friends and family members. Furthermore, when health promotion and disease prevention

messages are built on the cultural strengths and beliefs of the targeted AAPI community, they are more likely to be adopted by the target audience, integrated into daily life, and celebrated by the broader community.

The Office of Disease Prevention and Health Promotion, U.S. Department of Health and Human Services (HHS), partnered with the White House Initiative on Asian Americans and Pacific Islanders, the Office of Minority Health (HHS), and the American Public Health Association's Asian Pacific Islander Caucus to deliver better health information resources for Asian Americans, Native Hawaiians, and other Pacific Islanders on [healthfinder®](http://healthfinder.gov).

Available at www.healthfinder.gov/justforyou, the user-friendly Web site brings together multilingual information in Chinese, Hmong, Khmer, Korean, Laotian, Samoan, Thai, Tongan, and Vietnamese. The new consumer resource will be useful to caregivers, patients, and others searching for health information on behalf of individuals more comfortable in their native language.

This resource was developed through extensive community input and partnerships. Lessons learned from the interviews are available at <http://odphp.osophs.dhhs.gov/projects> in a report entitled "Understanding Our Users: How to Better Deliver Health Information Online to Asian Americans, Native Hawaiians, and Other Pacific Islanders."

THE IMPORTANCE OF INDIVIDUAL AND COMMUNITY RESPONSIBILITY

The knowledge, attitudes, and practices of the larger community strongly influence individual health. At the same time, individuals can have a powerful role in educating other members of the community about health-positive behaviors, advocating for the need to modify attitudes, and influencing others to eliminate unhealthy practices such as

The California Medical Association (CMA) recently announced the first statewide health initiative aimed at improving health literacy. In conjunction with California Literacy, Inc., a nonprofit organization dedicated to adult literacy, the initiative aims to improve provider-patient communication and to ensure that patients understand the information they receive from their health care provider. Health literacy involves the ability to understand basic health care communications, such as prescription instructions and insurance forms. An estimated 48 percent of Americans struggle with low health literacy, resulting in poor health outcomes and costing the health care system up to \$73 billion in added expenses every year.

The National Marrow Donor Program (NMDP) created a national education and recruitment initiative called Asian & Pacific Islander Donors Can Save Lives. The goal is to recruit more AAPIs to become volunteer donors. The increase in AAPI volunteers has improved the likelihood of identifying a matched potential donor for AAPI patients. The number of transplants performed for AAPI patients has more than tripled since 1995. Although more AAPI patients are finding donors for their transplants, they are still less likely than Whites to identify a matched donor. The NMDP is one example of how AAPI individuals can honor their responsibility to help others in the community. For more information on how to donate marrow, go to www.marrow.gov. Materials are available in English, Vietnamese, Korean, Chinese, and Japanese.

members, friends, neighbors, and others in the community.

Physicians and other health care providers who serve AAPIs need to be proactive in discussing health issues with their patients, especially because many AAPIs are reluctant to talk about personal health issues and unlikely to instigate such a conversation with a health care provider. Businesses can do more to create a healthier workforce by conducting health seminars for employees, promoting health education and awareness activities in the workplace, or even prominently displaying posters, flyers, and other health education materials that communicate critical health messages.

National and local philanthropic organizations can support public-private partnerships to adapt health education materials for AAPI audiences, disseminate health messages throughout AAPI communities, and establish community-based programs for

smoking, alcohol and drug abuse, and sedentary lifestyles.³

Everyone in AAPI communities has a role in improving the health of AAPI populations. AAPIs should learn more about health-positive behaviors and the risks associated with unhealthy behaviors. Armed with this knowledge, AAPIs can share their knowledge with family

health promotion and disease prevention. Grassroots organizations and community groups can use community events, cultural celebrations, and other venues to share health information and resources with AAPIs. These are just a few examples of opportunities to improve the health of AAPI communities.

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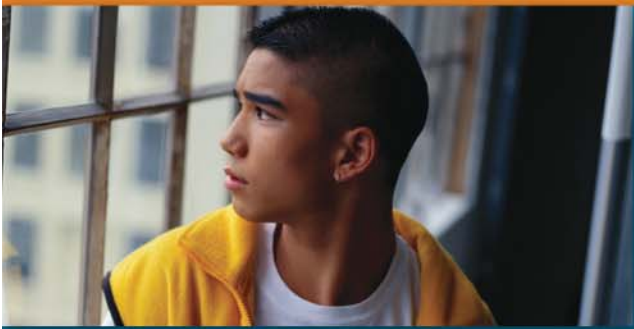
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CHAPTER FOUR

CHALLENGES FACING NATIVE HAWAIIANS AND OTHER PACIFIC ISLANDERS



O V E R V I E W

Native Hawaiian and Other Pacific Islander (NHOPI) populations generally are invisible within American culture, but the Office of Management and Budget (OMB) Statistical Policy Directive No. 15 is designed to “level the playing field” for NHOPI populations. OMB Directive 15 mandates the separation of “Asians” from “Native Hawaiians and Other Pacific Islanders” in Federal data collection efforts and allows respondents to designate more than one racial or ethnic category.

Pacific Islanders are broadly categorized in three groups. *Polynesians* generally include Native Hawaiians, Samoans, Tongans, Maoris, Cook Islanders, Tahitians, and Easter Islanders. *Micronesians* generally include Marshall Islanders, Palauans, Chamorros (Guamanians and Northern Mariana Islanders), Carolinians (both in the Caroline Islands and in the Commonwealth of the Northern Mariana Islands). *Melanesian* is a term used to categorize those

commonly referred to as Fijians as well as Papua New Guineans, Solomon Islanders, Ni-Vanuatu, and Kanaks. While the Melanesian Islands are not trust territories or Freely Associated States, people who live on these islands are considered to be Pacific Islanders. Native Hawaiians are the largest Pacific Islander group, followed by Samoans and Chamorros, which include indigenous Guamanians.

U.S.-associated Pacific Islands comprise three Flag Territories and three Freely Associated States. The Flag Territories are American Samoa, the Territory of Guam, and the Commonwealth of the Northern Mariana Islands. The Freely Associated States comprise the Federated States of Micronesia, which include Chuuk, Kosrae, Pohnpei, and Yap; the Republic of Palau; and the Republic of the Marshall Islands. Although Pacific Islanders are commonly regarded as a single group in data collection and service delivery, it is critically important to recognize that each of these Territories and Freely Associated States has a distinct language, culture, history, and politico-economic environment.

Across NHOPI populations, substantial variations exist in income, ethnic distribution, geographic location, proximity to basic and specialty health care services, and life expectancy. In general, the leading causes of death mirror those in the general U.S. population: heart disease, cancer, and injuries. Numerous studies suggest that obesity and overweight represent a serious public health challenge that directly compromises the health status of many NHOPI populations. Reported infant mortality rates among certain NHOPI subpopulations are three to eight times higher than the national infant mortality rate. In addition, NHOPI individuals and families living on the U.S. mainland have slightly different health care needs that may require culturally tailored health improvement strategies.

Perhaps the biggest challenge to reducing health disparities among NHOPI communities is the lack of health care infrastructure and capacity for delivering even the most basic health services. Geographically inaccessible facilities, the shortage of health care providers, outdated equipment, and other factors are formidable challenges that must be addressed to improve the health status of NHOPI populations in the Pacific Islands and U.S.-associated jurisdictions. Public- and private-sector programs must seize opportunities to support infrastructure development and capacity-building efforts throughout NHOPI communities.

Bold, new efforts must be undertaken to promote service delivery approaches that are culturally appropriate and to support alternative models of care that will be embraced in NHOPI communities. In addition, numerous opportunities are available to adapt health promotion and disease prevention messages for diverse NHOPI populations.

Native Hawaiians and Other Pacific Islanders (NHOPIs) have struggled to distinguish themselves from the broader categorization of Asian Americans and Pacific Islanders. Historically, their cultural dignity as diverse and indigenous peoples has been ignored, making NHOPI communities invisible within American culture.

The Office of Management and Budget (OMB) revised Statistical Policy Directive No. 15, Race and Ethnic Standards for Federal Statistics and Administrative Reporting,* to include two critically important changes affecting NHOPI populations. These changes include (1) separating “Asians” from “Native Hawaiians and Other Pacific Islanders,” and (2) allowing respondents completing household surveys, administrative forms and records, and other data collections (for example, the U.S. Census) to designate more than one racial or ethnic category. The Directive mandates that all Federal agencies must implement the directive by January 1, 2003. Not all agencies have done so.

Beyond the initial separation of data about NHOPIs and Asian Americans, there is an urgent need to collect, analyze, and disseminate disaggregated data on NHOPI communities. Without such a breakdown or further data disaggregation, data may be misanalyzed or misleading and may not adequately inform research, program planning, funding, and project implementation. Unfortunately, few

Federal agencies have implemented the requirements of OMB Directive 15, perpetuating the paucity of data on NHOPI subpopulations.

NHOPI DEMOGRAPHIC INDICATORS

Tables 4-1, 4-2, and 4-3 present demographic indicators for Native Hawaiian and Other Pacific Islander populations.

As noted in tables 4-1, 4-2, and 4-3, substantial demographic variation exists among Pacific Islander populations in terms of population size, ethnic composition, urban and rural distribution, household income, and life expectancy.

KEY HEALTH CONCERNS OF NHOPI COMMUNITIES

Although data on NHOPI health disparities are limited, a growing body of evidence suggests that, compared to the general U.S. population, NHOPI communities are at increased risk for poorer health outcomes. These potential disparities are complicated by the realities of economic hardship, poverty, joblessness, and underemployment in NHOPI communities; limited access to primary care and specialty medical care services; and underutilization of services. (Chapter 1 offers a more detailed discussion of these concerns as they relate to NHOPI populations.)

* Directive 15 is used in the collection of information on “racial” and “ethnic” populations not only by Federal agencies, but also, to be consistent with national information, by researchers, business, and industry as well. Source: Office of Management and Budget, Executive Office of the President. Revisions to the Standards for the Classification of Federal Data on Race and Ethnicity. Available online at www.whitehouse.gov/omb/fedreg/ombdir15.html.

TABLE 4-1
DETAILED NATIVE HAWAIIAN AND OTHER
PACIFIC ISLANDER GROUP POPULATION

Detailed Native Hawaiian and Other Pacific Islander Group	Population (alone or in any combination) *
TOTAL	874,414
Melanesian	
Fijian	13,581
Ni-Vanuatu	18
Papua New Guinean	224
Solomon Islander	25
Melanesian, not specified	315
Micronesian	
Carolinian	173
Chuukese	654
Guamanian or Chamorro	92,611
I-Kiribati	175
Kosraean	226
Mariana Islander	141
Marshallese	6,650
Palauan	3,469
Pohnpeian	700
Saipanese	475
Yapese	368
Micronesian, not specified	9,940
Polynesian	
Native Hawaiian	401,162
Samoan	133,281
Tahitian	3,313
Tokelauan	574
Tongan	36,840
Polynesian, not specified	8,796
Other Pacific Islander	174,912

Source: U.S. Census Bureau, Census 2000.

* The numbers by detailed Pacific Islander groups do not add up to the total population because the detailed Pacific Islander groups are tallies of the number of Pacific Islander responses rather than the number of Pacific Islander respondents. Respondents reporting several Pacific Islander groups are counted several times. For example, a respondent reporting "Samoan and Tongan" would be included in both the Samoan and the Tongan numbers.

TABLE 4-2
PACIFIC ISLAND POPULATION, AGE, ETHNIC, AND
GEOGRAPHIC INDICATORS*

Pacific Islander Group	Total Population	Age Distribution	Ethnic Distribution	Geographic Distribution
American Samoa	58,070	<15 years 38% >64 years 3%	Samoan 91% Tongan 4% Caucasian 3% Other 2%	Urban/State Center 33% Intermediate/Rural 67%
Commonwealth of the Northern Mariana Islands	66,559	<15 years 24% >64 years 2%	Chamorro 22% Filipino 31% Chinese 19% Carolinian 3% Other Pacific Islander 9% Other Asian 10% Other 4%	Urban/State Center 75% Intermediate/Rural 25%
Federated States of Micronesia (FSM)	112,732	<15 years 41% >64 years 4%	See States Below	Urban/State Center 27% Intermediate/Rural 63%
Kosrae, FSM	7,911	<15 years 43% >64 years 3%	Kosraen 92% Other Micronesian 2% Asian 5% Caucasian 1%	Urban/State Center 36% Intermediate/Rural 64%
Pohnpei, FSM	36,171	<15 years 44% >64 years 4%	Pohnpeian/proper 76% Pohnpei Outer Island 13% Chuukese 6% Kosraen 1% Asian 2% Other Pacific Islander 1% Other 1%	Urban/State Center 26% Intermediate/Rural 74%
Chuuk, FSM	56,517	<15 years 46% >64 years 4%	Chuukese 98% Asian 1% Other FSM or Pacific Islander 1%	Urban/State Center 31% Intermediate/Rural 69%
Yap, FSM	11,856	<15 years 41% >64 years 5%	Yapese 92% Asian 5% Other Micronesian 1% Other Pacific Islander 2%	Urban/State Center 62% Intermediate/Rural 38%
Guam	155,230 (1996 data)	<15 years 30% >64 years 7%	Chamorro 43% Filipino 23% Asian 20% Caucasian 14%	Urban/State Center 38% Intermediate/Rural 62%
Republic of the Marshall Islands	50,840	<15 years 43% >64 years 2%	Marshallese 97% Others 3%	Urban/State Center 65% Intermediate/Rural 35%
Republic of Palau	18,100 (1998 data)	<15 years 28% >64 years 7%	Palauan 73% Filipino 16% Chinese 3% Other 8%	Urban/State Center 71% Intermediate/Rural 29%

Source: Pacific Island Health Officers Association (PIHOA). Pacific Islands' Health Data Matrix. Honolulu, HI: PIHOA, December 2000.

* Unless otherwise noted, all data are 1999 data. All percentages are rounded.

TABLE 4-3
ANNUAL HOUSEHOLD INCOME, POPULATION GROWTH, AND LIFE EXPECTANCY INDICATORS*

Pacific Islander Group	Annual Average Household Income	Population Growth	Average Life Expectancy
American Samoa	\$18,219†	4%	72 years
Commonwealth of the Northern Marianas	\$19,093	6%	76 years
Federated States of Micronesia	(1996) \$8,645	2%	68 years
Kosrae	\$9,686	1%	65 years
Pohnpei	N/A	2%	N/A
Chuuk	\$5,443	2%	64 years
Yap	\$11,972	1%	67 years
Guam	\$46,567	3%	(1995) 74 years
Republic of the Marshall Islands	\$6,840	(1996) 4%	64 years
Republic of Palau	\$11,856	2%	(1998 projections) 67 years

Source: Pacific Island Health Officers Association (PIHOA). Pacific Islands' Health Data Matrix. Honolulu, HI: PIHOA, December 2000.

* Unless otherwise noted, all data are 1999 data. All percentages are rounded.

† Household income data for American Samoa was obtained from 2000 Census data.

Table 4-4 presents the leading causes of death among Pacific Islander populations. The leading causes of death among these populations mirror those in the mainland United States: cardiovascular disease, cancer, and injuries. Surprisingly, endocrinologic/nutritional and respiratory diseases also rank high on the list of leading causes of death among Pacific Islanders. Particularly alarming is the fact that perinatal deaths are the third leading cause of death on the island of Kosrae.

The following section provides additional evidence of serious public health challenges facing NHOPI populations.

Cancer

Approximately 106 of every 100,000 Hawaiian women are diagnosed with breast cancer—a rate substantially higher than that those for Japanese (82.3 per 100,000), Filipina (73.1 per 100,000), Chinese (55.0 per 100,000), and Korean (28.5 per 100,000) women. In addition,

TABLE 4-4
TOP FIVE LEADING CAUSES OF DEATH AMONG PACIFIC
ISLANDER POPULATIONS*

Pacific Islander Group	Leading Causes of Death
American Samoa (1995)	<ol style="list-style-type: none"> 1. Diseases of the Heart 2. Malignant Neoplasms 3. Cerebrovascular Disease 4. Accidents and Adverse Effects 5. Septicemia
Commonwealth of the Northern Marianas	<ol style="list-style-type: none"> 1. Diseases of the Circulatory System 2. Accidents and Adverse Effects 3. Malignant Neoplasms 4. Symptoms, Signs, Ill-Defined Conditions 5. Infectious and Parasitic Diseases
Federated States of Micronesia	<ol style="list-style-type: none"> 1. Circulatory System 2. Endocrine/Metabolic 3. Injuries/Poisoning 4. Diseases of the Respiratory System 5. Cancer
Kosrae	<ol style="list-style-type: none"> 1. Diseases of the Circulatory System 2. Endocrine/Nutrition 3. Diseases and Conditions Originating in the Perinatal Period 4. Respiratory Diseases 5. Cancer
Pohnpei	<ol style="list-style-type: none"> 1. Diseases of the Circulatory System 2. Respiratory Diseases 3. Injuries/Poisoning 4. Endocrine/Nutrition 5. Cancer
Chuuk (1994)	<ol style="list-style-type: none"> 1. Diseases of the Circulatory System 2. Endocrine/Nutrition 3. Cancer 4. Injury/Poisoning 5. Respiratory Diseases
Yap	<ol style="list-style-type: none"> 1. Respiratory Diseases 2. Cancer 3. Circulatory System Diseases 4. Injuries/Poisoning 5. Endocrine/Nutrition
Guam (1995)	<ol style="list-style-type: none"> 1. Diseases of the Heart 2. Malignant Neoplasms 3. All Other Accidents 4. Cerebrovascular Disease 5. Motor Vehicle Accidents
Republic of the Marshall Islands (1996)	<ol style="list-style-type: none"> 1. Sepsis/Septicemia and Septic Shock 2. Diseases of the Heart 3. Malignant Neoplasms 4. Pneumonia 5. Renal Failure/Disease
Republic of Palau	<ol style="list-style-type: none"> 1. Diseases of the Heart 2. Injuries 3. Stroke/Hypertension 4. Cancer 5. Respiratory Illness

Source: Pacific Island Health Officers Association. Pacific Islands' Health Data Matrix.
Honolulu, HI: PIHOA, December 2000.

* Unless otherwise noted, all data are 1999 data.

The National Cancer Institute (NCI) is supporting the Imi Hale Native Hawaiian Cancer Research and Training Network project, which is examining existing tumor registry data (including sociodemographic and classic prognostic factors) for patients diagnosed between 1995 and 1997. The study is comparing differences among Hawaii's five major ethnic groups—Native Hawaiian, Caucasian, Chinese, Filipino, and Japanese. It is the first project to request access to archived breast cancer tissue in a newly formed tissue bank repository of the Cancer Research Center of Hawaii.

NCI also administers the CURE (Continuing Umbrella of Research Experience) program. The goal of this program is to increase the pool of trained researchers, including persons having origins in any of the Pacific Islands. Included in this group are Native Hawaiians, Guamanians, Samoans, Fijians, Polynesians, Tongans, Micronesians, Tahitians, Marshallese, Melanesians, and other Pacific Islanders.

times greater than that for White women in the United States. In addition, Marshallese women may experience cervical cancer rates 75 times higher than those for White women in the United States.² The Marshallese experience higher rates of cervical, breast, thyroid, and genito-urinary cancers than do those who live on Micronesian islands. Many in the NHOPI community believe that these high rates of cancer may be linked to radiation fallout from U.S. nuclear bomb testing in the 1950s and nuclear waste dumping in the U.S.-associated Pacific Island jurisdictions, particularly on the Marshall Islands.³

lung cancer rates for Hawaiian men (89.0 per 100,000) exceed those for Vietnamese (70.9 per 100,000), Korean (53.2 per 100,000), and Chinese (52.1 per 100,000) men. Lung cancer is the leading cause of death for Hawaiian men (88.9 per 100,000).¹ Although these data suggest that NHOPI communities are at increased risk for various forms of cancer, more data are needed to further document these suspected disparities and opportunities for culturally tailored prevention activities and interventions. Data based on NHOPI subpopulations also will clarify potential risk factors such as smoking, exposure to secondhand smoke, hepatitis B, and insufficient access to mammography and cervical cancer screening, all of which contribute to apparent higher rates of cancer-related morbidity and mortality among NHOPI communities.

The rate of breast cancer incidence and mortality for Marshallese women is five

Cardiovascular Disease

According to the National Heart, Lung, and Blood Institute, Native Hawaiians disproportionately suffer the burden of heart disease compared to other ethnic groups in Hawaii. In 1990, the mortality rate for heart disease for full-Hawaiians was 4.7 times higher than for "all races" and 2.5 times higher than for part-Hawaiians, and the mortality rate for part-Hawaiians was 1.9 times higher than that for "all races." Although the mortality rate improved for "all races" between 1980 and 1990, the rate for Hawaiians worsened.⁴ The age-adjusted death rate for Native Hawaiians is 333.4 per 100,000, making heart disease the leading cause of death for this population.⁵ The death rate from heart disease is 66 percent higher among Native Hawaiians than among Hawaii's total population.⁶ The age-adjusted death rate per 100,000 population is 340.8 for full-Hawaiians,

125.8 for part-Hawaiians, and 89.0 for non-Hawaiians.⁷

The disparity for heart disease among Native Hawaiian populations is reasonably well documented. However, far less is known about the prevalence of heart disease among other Pacific Islander populations. What few data exist suggest alarmingly high rates of heart disease among other Pacific Islanders. A California study found that Guamanians (Chamorros), Samoans, and the group classified as “other islander” had the highest death rates from coronary heart disease in the State.⁸ More data are needed to fully understand the incidence and prevalence of cardiovascular and related diseases among other Pacific Islander subpopulations.

The risk factors for heart disease are well documented. However, a growing body of evidence suggests that NHOPI populations are at substantially increased risk for heart disease because of numerous risk factors and high-risk behaviors, including high blood cholesterol, high blood pressure, smoking, obesity, physical inactivity, and diabetes mellitus.

High Blood Pressure

Also known as hypertension, high blood pressure is a risk factor for heart disease, kidney disease, and stroke. Most people with high blood pressure are unaware of their condition, especially if they lack access to routine health maintenance services to have their blood pressure checked regularly.

In Hawaii, Native Hawaiians have the highest incidence of hypertension. The

prevalence of high blood pressure is 16 percent among Native Hawaiians, compared to 14 percent for the total State population.⁹ The Molokaʻi Heart Study revealed that hypertension is prevalent in about 25 percent of the study group.¹⁰ Among other Pacific Islanders, virtually no data are available on the incidence and prevalence of hypertension; however, given the high rates of heart disease and other conditions commonly observed in these populations, other Pacific Islanders are likely to experience higher rates of hypertension than the general population. Additional research is needed to further document rates of hypertension among NHOPI communities and to develop culturally relevant health promotion and disease prevention interventions to reduce suspected disparities.

Smoking

The prevalence of smoking is higher among Native Hawaiians than among all other ethnic groups in Hawaii. The prevalence rate of smoking among Native Hawaiians is 27 percent, compared to 19 percent for the total State population.¹¹ Another study found that 34 percent of Native Hawaiian females and 42 percent of Native Hawaiian males are smokers, with the highest prevalence rate (48 percent) observed among males age 20 to 29 years.¹² Little is known about the prevalence of smoking among other Pacific Islander populations; however, anecdotal information suggests that smoking rates in other Pacific Islander communities may be higher than anticipated. Additional research is needed to determine if other Pacific Islander populations are at increased risk for heart disease, certain

forms of cancer, and other diseases as a result of smoking behaviors.

Obesity

Overweight is defined as a body mass index (BMI) of 25 to 29.9 kg/m². Obesity is defined as a BMI of 30.¹³ Samoans and Native Hawaiians have some of the highest rates of overweight and obesity in the world. Native Hawaiian men and women are reported to have an average BMI of 31 and 30, respectively.¹⁴ Samoans age 20 and older, regardless of where they live, consistently show high levels of obesity. Samoan men and women from the Independent State of Samoa have an average BMI of 26 and 28, respectively. Hawaii Samoans have an average BMI of 31 for men and 33 for women. California Samoans show an average BMI of 35 for men and 34 for women. American Samoans have an average BMI of 30 for men and 33 for women.¹⁵

The prevalence of overweight and obesity in the Native Hawaiian population is alarming. The mean BMI for Native Hawaiian women is 30.0, and the mean for Native Hawaiian men is 30.9.¹⁶ Thirty percent of Hawaiians age 45 to 54 are overweight.¹⁷ In 1990, 42 percent of Native Hawaiians were reported to be overweight—a number that increased to more than 43 percent in 1992. The prevalence of overweight for the total population in Hawaii was 21.5 in 1990 and 24.9 in 1992.¹⁸ In the Moloka'i Heart Study, 64 percent of Hawaiian participants were obese.¹⁹

Obesity disproportionately affects older people, especially women, in Micronesia. In a study in the Marshall Islands, more

than half of all women were classified as overweight. In a similar study in Guam, more than two-thirds of Chamorros were classified as overweight.²⁰

Clearly, overweight and obesity constitute an enormous public health challenge for health care providers and programs targeting NHOPI communities. Additional research is needed to further clarify the etiologic basis for these conditions in NHOPI populations and to develop culturally tailored prevention messages to reduce the occurrence of these conditions among NHOPIs.

Physical Inactivity

Physical activity reduces the risk for coronary heart disease, hypertension, colon cancer, diabetes, and illness in general. A physically active lifestyle also is associated with improved mental health, reduced stress, and a positive self-image. The *HealthierUS* initiative, managed by the President's Council on Physical Fitness and Sports, encourages all Americans to be physically active every day²¹—a recommendation that is supported by decades of scientific evidence.²²

The Hawaii Department of Health defines sedentary lifestyle as no physical activity or physical activity fewer than three times per week or less than 20 minutes per occasion. Using this definition, 76.3 percent of Filipinos, 57.1 percent of Japanese, and 54.7 percent of full-Hawaiians and part-Hawaiians live sedentary lifestyles.²³ Additional data are necessary to shed more light on which segments of the Native Hawaiian population are more likely to live

sedentary lifestyles. At the same time, virtually no data are available on sedentary lifestyles among other Pacific Islander populations. Population-based research is needed to identify culturally appropriate interventions to increase physical activity in NHOPI communities.

Diabetes

Diabetes mellitus is an independent risk factor for coronary heart disease, and the risk doubles when hypertension is present.²⁴

A study of Native Hawaiians in two rural communities examined the prevalence of diabetes and glucose intolerance. Results showed a 22.4-percent age-standardized prevalence of type 2 diabetes in people age 30 years and older. Prevalence was highest in people age 60 to 64 years, who had a rate of 40 percent—four times higher than that of the non-Hispanic White population surveyed in the National Health and Nutrition Examination Survey.²⁵ Analysis of data collected in Hawaii from 1996 to 2000 showed that Native Hawaiians were 2.5 times more likely to have diabetes than were non-Hispanic White residents of similar age.²⁶ In contrast, the prevalence of diabetes in some isolated Polynesian groups may be relatively low, although higher among women than men. Researchers attributed the rate differentials to increased physical activity among men and more sedentary lifestyles and higher calorie consumption among women. In Western Samoa, diabetes prevalence in a rural community (3.4 percent) was less than half the rate in an urban setting (7.8 percent), even after adjusting for body weight. Researchers

found that rural residents exhibit significantly higher rates of physical activity than do their urban counterparts.²⁷

Obesity is a major risk factor for type 2 diabetes among all races and ethnic groups. The degree to which obesity is a risk factor for diabetes depends on overall weight and the location of excess weight on the body. Central or upper-body obesity is a stronger risk factor for type 2 diabetes than is excess weight carried below the waist.²⁸ In a study comparing Japanese people in Japan with Japanese people who immigrated to Hawaii, the Hawaiian Japanese had a higher rate of obesity and twice the prevalence of type 2 diabetes.²⁹

Data collected from 1988 to 1995 suggest that Native Hawaiians are twice as likely to be diagnosed with diabetes as are White residents of Hawaii.³⁰ Data regarding diabetes among certain ethnic groups in Hawaii are alarming. Filipinos had the highest prevalence of both total cases (21.8 percent) and new cases (15.5 percent) of diabetes. The age-adjusted prevalence of diabetes among Koreans was 19.7 percent of total cases and 11.7 percent of new cases.³¹

Prenatal Care, Low Birthweight, and Infant Mortality

Rates of early prenatal care among Samoan and Guamanian women are extremely low. In 1996, 81.2 percent of women in the United States received early prenatal care, compared to only 48.4 percent of Samoan women, 66.4 percent of Guamanian women, and

The “Back to Sleep” campaign, administered by the National Institute of Child Health and Human Development, recently launched a new partnership with the National Coalition of 100 Black Women, the National Association for the Advancement of Colored People, and the Alpha Kappa Alpha Sorority, Inc., to develop an outreach kit targeting African American communities.

African American infants are more than twice as likely to die from sudden infant death syndrome (SIDS) during the first year of life than are White infants.

NHOPI infants also are at increased risk for SIDS. The partnership described above could be replicated via a public-private partnership involving NHOPI organizations that are uniquely qualified to adapt the campaign message of placing infants on their backs to sleep, to disseminate the message to NHOPI communities, and to help eliminate the tragedy of SIDS in NHOPI populations.

78.5 percent of full-Hawaiian and part-Hawaiian women.^{32, 33} A California study found an even lower rate of early prenatal care among Guamanian women (45.7 percent) and that the rate among Asian Americans and Pacific Islanders overall is low compared to Whites.³⁴

Full-Hawaiian and part-Hawaiian infants are more likely to be born at low birthweight (10.1 percent) than are infants in the general U.S. population (7.1 percent).³⁵ Among all Asian American and Pacific Islander groups, full-Hawaiian and part-Hawaiian women are most likely to smoke during pregnancy (15.3 percent and 13.3 percent, respectively).³⁶

TABLE 4-5
INFANT MORTALITY RATES IN PACIFIC ISLANDER COMMUNITIES

Pacific Islander Group	Infant Mortality Rate (per 1,000 live births)
American Samoa	10*
Commonwealth of the Northern Mariana Islands	8
Federated States of Micronesia	
Kosrae	49
Pohnpei	42
Chuuk	53
Yap	22
Guam	9
Republic of the Marshall Islands	26
Republic of Palau	11

Source: Pacific Island Health Officers Association. Pacific Islands’ Health Data Matrix. Honolulu, HI: PIHOA, December 2000.

* American Samoa infant mortality data was provided by the Central Intelligence Agency World Fact Book.

Although infant mortality rates have declined among most racial and ethnic groups in the United States in recent years to 6.9 per 1,000 in 2000,³⁷ NHOPI infants are at serious risk for infant death compared to infants in the general population.^{38, 39} Table 4-5 presents infant mortality data for Pacific Islander populations.

All Pacific Islander groups have infant mortality rates that exceed those of the general U.S. population. In particular, infants born in the Republic of the Marshall Islands and the Federated States of Micronesia have infant mortality rates that are three to eight times higher than those of the general U.S. population.

BARRIERS TO REDUCING NHOPI HEALTH DISPARITIES

Reducing health disparities among NHOPI populations represents a formidable challenge. Similar to other racial and ethnic groups in the United States, addressing key health concerns among NHOPIs will require culturally tailored, holistic approaches to prevention and treatment that reflect the cultural diversity and beliefs of NHOPI communities. However, unlike some other racial and ethnic groups in the United States, NHOPI communities typically experience seemingly insurmountable geographic barriers to receiving high-quality prevention and treatment services. The U.S.-Pacific Basin has a dire shortage of health care facilities, and the few facilities that exist are sorely understaffed. Even if facilities were readily accessible and adequately staffed, NHOPI families may underutilize programs that are not responsive to their cultural norms and values.

Health care systems—especially mainstream, financially driven health care systems in the United States—generally do not recognize the value of holistic approaches to health. They also do not typically recognize the importance among NHOPI communities of involving family members or the community in maintaining health. Many Pacific Islanders believe that health encompasses physical, social, mental, and spiritual well-being, and the family plays an important role in shaping attitudes about health and influencing practices. As a result, prevention and treatment

approaches employed by mainstream health care systems are inappropriate and often result in services being underutilized—or not used at all.⁴⁰

Leveraging the Cultural Strengths of NHOPI Communities

With these factors in mind, a growing awareness recognizes that culturally competent health care services for NHOPI communities should be driven by the following core principles:

- At the core of reducing health disparities among NHOPI communities is the need to recognize the cultural strengths of these populations. The values, beliefs, attitudes, motivation, knowledge, and skills of NHOPI communities can be valuable assets in



Commissioners Ong, Khan, Carlota, and Radewagen, along with Deputy Secretary Claude Allen, hear about the healing power of various plants grown at the Waianae Coast Comprehensive Health Center.

"As one of the largest primary health care providers in a predominantly Native Hawaiian neighborhood, the Waianae Coast Comprehensive Health Center (WCCHC) is a leader in effectively incorporating alternative therapies, Native Hawaiian beliefs and practices into the world of western medicine. It also serves as a regional training center for health providers in the Pacific Islands and Micronesia. The WCCHC is a great model of a health delivery system that has successfully addressed the unique health care needs of the AAPI communities. WCCHC is a federally qualified community health center, an excellent example of what the Expansion of the Community Health Center Initiative would help fund."

--Commissioner Barbara Marumoto

promoting health and preventing disease.

- Health care providers and agencies should use a family-centered approach to promote health, prevent disease, and enforce treatment plans to improve health. NHOPI families can play a powerful role in enhancing resiliency and improving health.
- Health care providers and agencies should be aware of the importance of spirituality in NHOPI culture.
- NHOPI communities themselves can be a powerful healing agent. Any attempt to promote health and prevent disease should involve community leaders, family leaders, chiefs, and leaders of community organizations in the development, implementation, delivery, and evaluation of activities.
- In addition to taking a family-centered approach, program planners should ensure that programs targeting NHOPI communities are built on a holistic philosophy that recognizes the interconnectedness of their culture and the relationships that are important to NHOPIs.

The Agency for Healthcare Research and Quality funds the Hawaii Minority Research Infrastructure Support Program. This program is designed to build research infrastructure to measure and evaluate racial health disparities for AAPIs and to provide developing researchers with the mentorship and training necessary to become independent investigators.

- Storytelling is an important therapeutic agent in NHOPI communities. Modern messages about health promotion and

disease prevention can be incorporated into ancient stories as a way to encourage health-positive behaviors.

- Health care providers and program planners should empower clients to be active participants in the healing and treatment process.
- Providers and programs should consider the diverse cultural and historical contexts of NHOPI communities.
- Individuals and programs that serve NHOPI populations must be prepared to learn from their NHOPI clients. An open mind and receptiveness to non-Western approaches to health maintenance enable individuals and organizations to improve their awareness of these cultures and the strengths they bring to the process of health promotion and disease prevention.

Health Care Infrastructure and Capacity in the U.S.-Pacific Basin

Many NHOPI communities lack the infrastructure, capacity, equipment, and training to deliver health care services.

Without facilities, reliable funding streams, up-to-date equipment, and an adequate supply of culturally competent health care providers and medical specialists, NHOPI populations will continue to lack access to health care—and health disparities may persist.

Table 4-6 presents data on the ratio of health care providers in the U.S.-associated Pacific Island jurisdictions. Some jurisdictions and States are significantly more medically

TABLE 4-6**RATIO OF HEALTH CARE PROVIDER-TO-POPULATION IN THE PACIFIC ISLANDS**

Pacific Islander Group	Physician-to-Population Ratio	Nurse-to-Population Ratio	Health Extender-to-Population Ratio	Dentist-to-Population Ratio
American Samoa	1:1,559	1:304	1:6,682	1:6,682
Commonwealth of the Northern Mariana Islands	1:2,237	1:559	1:2,571	1:17,544
Federated States of Micronesia	1:1,529	1:281	1:723	1:7,563
Kosrae	1:750	1:174	1:2,439	N/A
Pohnpei	1:1,522	1:301	1:1,773	1:5,615
Chuuk	1:2,325	1:346	1:599	1:8,887
Yap	1:800	1:219	1:447	1:11,178
Guam	1:484	1:191	1:6,749	1:2,218
Republic of the Marshall Islands	1:2,194	1:478	1:911	1:14,812
Republic of Palau	1:556	1:273	1:574	1:4,306

Source: Pacific Island Health Officers Association. Pacific Islands' Health Data Matrix. Honolulu, HI: PIHOA, December 2000.

underserved than are others. Guam appears to have the most favorable ratios of health care providers to population. All other jurisdictions and States have substantially poorer ratios of physicians and dentists to population. These data underscore the need to expand the health professions workforce in Pacific Islander communities.

Table 4-7 summarizes the annual health budgets and per capita health care spending in the U.S.-associated Pacific Islands. It also provides data regarding health insurance coverage, Medicare and Medicaid eligibility, and the places

Although many Federal agencies focus on a particular disease or condition, most agencies recognize the complex health care needs facing communities. For example, the Substance Abuse and Mental Health Services Administration (SAMHSA) understands that people with mental and addictive disorders also need primary health care services to meet basic health needs, or that homelessness may inhibit treatment progress. As a result, SAMHSA funds a portfolio of initiatives designed to get Federal money into the hands of communities with the most complex and challenging needs. This focus at the Federal level—a focus that is not exclusively limited to SAMHSA—coincides with the needs of NHOPI communities. Yet many NHOPI communities lack the know-how and resources to compete effectively for limited Federal grant funding. Training and technical assistance will be critical to leveling the playing field for NHOPI communities.

TABLE 4-7
ANNUAL HEALTH BUDGETS, INSURANCE COVERAGE,
MEDICARE/MEDICAID ELIGIBILITY, AND REFERRAL SITES IN THE
PACIFIC ISLANDS

Pacific Islander Group	Annual Health Budget (in \$)	Annual Health Budget per Capita (in \$)	Major Referral Sites
American Samoa	\$21,403,500	\$369	Honolulu New Zealand
Commonwealth of the Northern Marianas	\$33,920,121	\$509	Honolulu San Diego
Federated States of Micronesia	\$11,200,000	\$99	Manila Honolulu Guam
Kosrae	\$848,000	\$148	Manila Honolulu
Pohnpei	N/A	N/A	N/A
Chuuk	\$2,863,000	\$80	N/A
Yap	\$2,034,212	\$180	Manila Honolulu Guam
Guam	\$81,000,000	\$510	Honolulu Los Angeles
Republic of the Marshall Islands	\$12,600,000	\$248	Honolulu Manila
Republic of Palau	\$4,247,500	\$339	Honolulu Manila Guam

Source: Pacific Island Health Officers Association. Pacific Islands' Health Data Matrix, December 2000. Honolulu, HI: PIHOA, 2000.

to which patients must go for more intensive care. Guam and the Commonwealth of the Northern Marianas have the highest annual per capita spending as well as the highest rates of health insurance coverage. Populations in Samoa, Northern Mariana, and Guam are eligible for Medicare and Medicaid services—at capitated reimbursements—whereas those in the Marshall Islands, Palau, and the Federated States of

Micronesia generally are not eligible for Medicare and Medicaid services.

Another major challenge to health care access is the remoteness of the U.S.-Pacific Island jurisdictions and some rural areas in neighbor islands in the State of Hawaii. Health policymakers are well aware that rural Americans often have difficulty accessing basic health care services. One can imagine then how difficult it may be for NHOPIs who are

hundreds of miles from a primary care facility and the only way to access those services is by airplane or boat. Although opportunities to employ technologies such as telemedicine and telehealth may exist to address geographic barriers to the delivery of care, most islands in the U.S.-Pacific Basin lack the infrastructure to use such technologies. Even if organizations had the capacity, facilities, and equipment to use telemedicine and telehealth technologies, the cost of services would be prohibitive without substantial investments by Federal, State, jurisdiction, foundation, or corporate sources.

- Is there an adequate supply of culturally competent primary care practitioners, medical specialists, and social service providers?
- What are the cultural and access barriers that inhibit residents from receiving care?
- Do existing programs integrate alternative treatments and therapies that residents believe are effective?
- Do current programs have “buy-in” from the communities they serve?

Assessing Current Infrastructure and Capacity

The first step toward reducing health disparities is to assess the current service delivery infrastructure within NHOPI communities. Ideally, assessments should be conducted at the community level and should answer the following questions:

- What are the community’s most urgent health needs?
- What are the major gaps in services?
- To what degree are existing programs underfunded and understaffed?
- Are there opportunities to integrate existing programs to improve coordination, reduce duplication, and enhance efficiency?
- Do residents have transportation to existing services?

The Health Resources and Services Administration, which administers the Ryan White Comprehensive AIDS Resources Emergency Act, uses a mathematical formula for allocating HIV prevention and treatment resources to States and municipalities. A key component of the formula is the degree to which States and communities have been hit hard by HIV/AIDS, which is determined largely by available data on HIV/AIDS incidence and prevalence.

For NHOPI communities—where a limited infrastructure exists for collecting and reporting HIV incidence data and where HIV/AIDS is widely believed to be dramatically underreported—such underreporting directly translates into fewer dollars to support HIV prevention programs and provide much-needed HIV primary medical services.

Developing a Community Plan

The second step toward reducing NHOPI health disparities is to develop a comprehensive plan for enhancing each community’s capacity to meet local needs. In all likelihood, the key to enhancing capacity will be securing additional funding. Additional resources are needed to establish new facilities and programs on the Hawaiian Islands and

Ho`oponopono is a traditional Hawaiian therapy commonly used in family counseling and solving interpersonal problems. This therapy offers a formal, culturally accepted process for self-reflection and conflict resolution. It also provides a ritual of apology and forgiveness between patients and families, between patients and staff members, and among staff members themselves.

Ho`oponopono is based on the traditional Native Hawaiian view that disease comes from a lack of internal balance (*mama* and *pono*). The primary focus of the intervention is to restore spiritual, physical, and emotional balance, opening the door to psychological and physical healing.

Although no scientific evidence exists to support that *Ho`oponopono* works, the bottom line is that many Native Hawaiian people believe that it does. And there is no denying that *Ho`oponopono* represents a common-sense, nonmedical approach that merits further study and replication in mainstream medicine.

other U.S. jurisdictions in the Pacific Basin. Existing prevention and treatment programs require additional funding to improve their facilities, to open satellite sites, to create outreach programs, to establish culturally relevant health promotion and disease prevention programs, to hire and train staff, to provide transportation, and to educate the community that services are available.

Another critically important component of the community health planning process is to involve key health ministries, community leaders, chiefs, businesses, and respected and trusted individuals in all phases of the planning process—from identifying local resources, to tapping underutilized local resources, to establishing networks of care, to developing measures to evaluate success.

When key leaders are involved in the planning process, they are more likely to develop a vested interest in the project's success.

Implementing the Community Action Plan

The third step toward reducing NHOPI health disparities is to provide technical assistance so that communities have the know-how to operationalize their action plans, maximize existing resources, and create efficient networks of care. Health care facility staff members may require training and technical assistance to learn how to develop a winning grant application. New programs will need assistance in

securing startup funds. The Federal Government perhaps offers the largest amount of grant resources available to NHOPI communities.

Increasing Data Collection and Research

Another major challenge to securing additional funding for NHOPI communities is the severe paucity of data on the health status of NHOPI populations. Without question, the lack of data generally translates into a lack of funding. Indeed, as data begin to document health disparities, jurisdictions find themselves better positioned to compete for limited resources for capacity building, infrastructure development, prevention, and treatment.

Promoting Culturally Competent Alternatives to Care

The traditional medical model of care—by itself—is not well received in most NHOPI communities. However, when the traditional medical model is combined with alternative treatments and therapies that are widely used and accepted by the target population, patients are more likely to accept it and more likely to return for additional care.

Alternative treatments and therapies come in many shapes and forms. Although scientific evidence is not always available to support the validity of some therapies, health care providers must accept that some non-Western treatments are deeply embedded in NHOPI cultures. Health care providers serving NHOPI communities must open their minds to these therapies, become familiar with their uses, and seek out opportunities to integrate these therapies into clinical practice.

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An Action Agenda for the Future

This report is intended to serve as a major step forward in increasing awareness of Asian American and Pacific Islander (AAPI) health concerns among policymakers, program planners, service providers, communities, and advocates. The President's Advisory Commission on Asian Americans and Pacific Islanders also hopes that this report will provide the launching pad for ensuring that AAPI communities will have a voice in the larger health care debate.

Indeed, the future holds many exciting opportunities to ensure that AAPIs enjoy healthy and productive lives. To ensure our progress in the years to come, the President's Advisory Commission on Asian Americans and Pacific Islanders recommends that the Federal Government consider establishing the Asian American and Pacific Islander Health Service (AAPIHS). The AAPIHS could lead national efforts to ensure that existing resources and programs are adequately coordinated, and to promote increased recognition of the needs of AAPI communities in the policymaking and program development process at the Federal, State, and community levels. Additional roles for the AAPIHS could include cultivating public-private partnerships to ensure broad and diverse input in the strategic planning process, to implement public health policies, to conduct new research, and to ensure a unified health improvement agenda that truly reflects the needs of AAPI communities.

The AAPIHS also could function as the entity responsible for implementing the recommendations included in this report.

For example, the AAPIHS could lead Federal efforts to:

- Ensure that the “Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity” are fully implemented and enforced
- Increase access to health care coverage for AAPI populations
- Encourage AAPI health care providers to practice in underserved AAPI communities
- Promote AAPI-focused research, health education, and public awareness efforts
- Identify AAPI-serving institutions
- Ensure that AAPI communities are represented in the policymaking and program development process
- Support holistic, strengths-based approaches to meeting the needs of AAPIs.

It is our hope that policymakers will find this report insightful and apply its contents to inform future policy directions. Program planners at the Federal, State, and local levels will be able to use this report as a guide in developing and implementing future programs, and in refining current program activities in which AAPI communities are not included. Service providers of all disciplines will be able to internalize the contents of this report and apply what they learned to the delivery of services in the clinical setting.

Communities can use this information to assess their readiness to serve a growing

AAPI population and to determine what steps need to be taken to develop the infrastructure and capacity to serve AAPI families effectively. And finally, advocates will have the opportunity to use this report to ensure that the voices of AAPI peoples throughout the United States are heard.

As noted above, this report merely constitutes a starting point for future action. It is not intended to paint a comprehensive portrait of our

community—in terms of the ethnic diversity within AAPI populations, the disparities we experience, and the barriers that separate many in our community from good health. The President’s Advisory Commission on Asian Americans and Pacific Islanders invites others throughout the AAPI community to share their ideas, perspectives, and solutions. We share our challenges, so we must share responsibility for developing workable solutions to the challenges we face.

APPENDIX

SCHEDULE OF PUBLIC MEETINGS AND SITE VISITS FOR THE PRESIDENT'S ADVISORY COMMISSION ON ASIAN AMERICANS AND PACIFIC ISLANDERS

On November 28, 2001, after the Commission was formally sworn in by Secretary of Health and Human Services *Tommy G. Thompson*, the full Commission held a 2-day hearing in **Washington, DC**. Key community leaders were invited to discuss current AAPI concerns. A number of Federal agency representatives also presented and shared with the Commissioners current Federal activities and programs being directed toward the AAPI communities.

On December 1, 2001, the Commission accompanied Secretary of Labor *Elaine Chao* to New York to visit the Asian American community affected by the September 11 World Trade Center tragedy.

On January 12, 2002, a town hall meeting in **Phoenix, Arizona**, was organized by the community with assistance from local Commissioner *Garry Ong*. Also in attendance were *Dr. John B. Tsu* and other Federal and administration representatives, including *Conrad Lee* (Small Business Administration Region X, Regional Administrator) and *Ed Moy* (The White House Office of Personnel, Special Assistant to the President for Presidential Personnel).

On May 1-3, 2002, the Commission convened their first official public meeting in **Washington, DC**. The testimonies gathered during the 2-day public meeting

set the framework for the Commission as they considered some of the issues more relevant to reaching out to the underserved AAPI populations.

On June 6-7, 2002, the Commission visited two cities: **Seattle, Washington**, and **Portland, Oregon**. Five members of the Commission, *Dr. John B. Tsu*, *Mary Ling*, *Representative Barbara Marumoto*, *Garry Ong*, and *Michelle Steel*, participated in the site visits and roundtable meetings. Federal representatives present included *Caroline Oakley* (Department of Health and Human Services Region X, Secretary's Regional Representative), *Walter Liang* (Department of Labor Region X, Secretary's Regional Representative), *John Meyers* (Department of Housing and Urban Development Region X, Regional Director), and *Conrad Lee* (Small Business Administration Region X, Regional Administrator).

On June 20-21, 2002, the Commission visited **Atlanta, Georgia**. Five members of the Commission, *Dr. John B. Tsu*, *Dr. Lupo Carlota*, *Sunny Park*, *Joe Ting*, and *Bao Ky Vu*, participated in the site visits. Federal representatives included *Costas Miskis* (Department of Health and Human Services Region IV, Secretary's Regional Representative) and *Nuby Fowler* (Small Business Administration Region IV, Regional Administrator).

On July 24-25, 2002, the Commission visited **Minneapolis/St. Paul, Minnesota**. Three members of the Commission, *Dr. John B. Tsu*, *Joe Ting*, and *Michelle Steel*, participated in the site visits and community roundtable meetings. Federal representatives included *Corey Hoze* (Department of Health and Human Services

Region V, Secretary's Regional Representative) and *Dr. Nguyen Van Hanh* (Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement, Director).

On July 26, 2002, the Commission visited **Detroit, Michigan**. Three members of the Commission, *Dr. John B. Tsu*, *Sunny Park*, and *Dr. Lupo Carlota*, participated in the site visits and roundtable meetings. A community roundtable meeting was hosted at the University of Michigan, Dearborn campus, with the following Federal representatives: *Sunny Chico* (Department of Education, Secretary's Regional Representative) and *Conrad Valle* (Small Business Administration, District Director).

On August 8-9, 2002, the Commission visited **Orlando** and **Miami/Fort Lauderdale, Florida**. Five members of the Commission, *Dr. John B. Tsu*, *Garry Ong*, *Amata Radewagen*, *Jhoon Rhee*, and *Dr. Zachariah Zachariah*, participated in the site visits and roundtable meetings. Federal participants included *Costas Miskis* (Department of Health and Human Services Region IV, Secretary's Regional Representative), *Don Vargas* (Department of Housing and Urban Development, Miami Office), *Victor Alvarado* (Department of Housing and Urban Development, Orlando Office), *Deborah Brown* (Small Business Administration, Deputy District Director), and *Cynthia Bernard* (Department of Health and Human Services, Centers for Medicare & Medicaid Services).

On August 20, 2002, the President announced his intention to appoint *Amanullah Khan* of Texas and *Shinq-Chern Liou* of California to be members of the

President's Advisory Commission on Asian Americans and Pacific Islanders.

On August 26, 2002, the Commission visited **Dallas, Texas**. Five members of the Commission, *Dr. John B. Tsu*, *Dr. Lupo Carlota*, *Joe Ting*, *Jhoon Rhee*, and *Mary Ling* participated in the site visits and roundtable meetings. Federal representatives included *Linda Penn* (Department of Health and Human Services Region VI, Secretary's Regional Representative), *Marina Tse* (Department of Education, Office of English Acquisition, Deputy Director), *M.J. Villarreal* (Department of Labor, Regional Administrator), *Dr. Nguyen Van Hanh* (Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement, Director), *Dr. James Farris* (Department of Health and Human Services, Centers for Medicare & Medicaid Services, Regional Administrator), *Louis Ybarra* (Department of Housing and Urban Development Region VI, Supervisory Operations Officer), *Lavan Alexander* (Small Business Administration, District Director), *Carl Edlund* (Environmental Protection Agency, Multimedia Planning and Permitting Division, Director), and *Donna Murray* (Department of Transportation, Federal Transit Administration, Transportation Program Specialist).

On August 27, 2002, the Commission visited **Houston, Texas**. Five members of the Commission, *Dr. John B. Tsu*, *Dr. Lupo Carlota*, *Joe Ting*, *Jhoon Rhee*, and *Mary Ling*, participated in the site visits and roundtable meetings. Federal representatives present included *Linda Penn* (Department of Health and Human

Services Region VI, Secretary's Regional Representative), *Marina Tse* (Department of Education, Office of English Acquisition, Deputy Director), *Gaydelle Lang* (Department of Education Region VI, Deputy Secretary's Regional Representative), *Dr. Nguyen Van Hanh* (Department of Health and Human Services, Administration for Children and Families, Office of Refugee Resettlement, Director), *Richard Whitford* (Office of Personnel Management, Employment Services, Acting Associate Director), *Milton Wilson* (Small Business Administration, District Director), *Stephen Brewer* (Department of Housing and Urban Development, Houston Field Office, Acting Director), *Carl Edlund* (Environmental Protection Agency, Multimedia Planning and Permitting Division, Director), and *Joan Erlich* (Equal Employment Opportunity Commission, District Director).

On September 16-17, 2002, the Commission visited **Los Angeles** and **Orange County, California**. Seven members of the Commission, *Dr. John B. Tsu*, *Mary Ling*, *Representative Barbara Marumoto*, *Sunny Park*, *Garry Ong*, *Michelle Steel*, and *Bao Ky Vu*, participated in the site visits and roundtable meetings. Federal representatives included *Chris McCabe* (Department of Health and Human Services, Intergovernmental Affairs, Director), *Emory Lee* (Department of Health and Human Services Region IX, Executive

Officer), *Melda Cabrera* (Department of Commerce, Minority Business Development Agency Region IX, Regional Director), *Rachel Baranick* (Small Business Administration, Santa Ana District Office, Deputy District Director), and *Pam Mokle* (Orange County Office on Aging, Executive Director).

On October 10-11, 2002, the Commission conducted their seventh site visit and second official public meeting in **Honolulu, Hawaii**. Eight members of the Commission, *Dr. John B. Tsu*, *Dr. Lupo Carlota*, *Dr. Amanullah Khan*, *Sean Liou*, *Representative Barbara Marumoto*, *Garry Ong*, *Amata Radewagen*, and *Michelle Steel*, participated in this site visit and town hall meeting. Federal participants included *Claude Allen* (Department of Health and Human Services, Deputy Secretary), *Michael Liu* (Department of Housing and Urban Development, Assistant Secretary), *David Cohen* (Department of Interior, Insular Affairs, Deputy Assistant Secretary), *Bruce Thompson* (Small Business Administration Region IX, Regional Administrator), and *Ruby Miller* (Department of Veterans Affairs, Center for Minority Veterans, Deputy Director).

On May 8-9, 2003, the Commission held an official public meeting in **Washington, DC**. All commissioners, except *Dr. Zachariah Zachariah*, participated in this meeting.

